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VOLUME II

1918

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THE MANAGEMENT OF WAR NEUROSES AND ALLIED DISORDERS IN THE ARMY*

COLONEL SIR JOHN COLLIE, M.D., A.M.S.

President of the Special Medical Board for Neurasthenia and Allied Nervous Diseases; Director of Institutions for Neurasthenia, under the Ministry of Pensions

WITH A REPORT OF REMARKS MADE BY LIEUTENANT-COLONEL ALDREN TURNER, C.B., M.D.

I APPRECIATE the difficulty of addressing an audience composed of the laity and members of the profession, and I am sure the distinguished medical men, whom I am pleased to see present, will understand that I should not be treating my audience as a whole with courtesy if I address it in too technical language, and they will forgive me if much of what I say is already within their knowledge.

Never before in the history of the world has mankind been subjected to so much strain and shock resulting in stress of mind and body as in the past three years, and never before has there been so apparent a necessity for sane and effective methods of treating the resulting disabilities.

It is unnecessary to trouble you with a definition of neurasthenia, or attempt any text-book description of it; that would not be difficult, but it would be unprofitable. We have, however, to consider the predisposing causes, the effects, and the treatment.

*A lecture delivered at the Royal Institute of Public Health in June, 1917. The article was originally published under the title, "The Management of Neurasthenia and Allied Disorders, Contracted in the Army," in *Recalled to Life*, a new British journal devoted to the care, re-education and return to civil life of disabled sailors and soldiers. It is here republished by special permission of Sir John Collie and the War Office of Great Britain.

Most, if not all, of the cases of neurasthenia arising in the Army are the result of actual concussions (shell shock) or the conditions prevailing in modern warfare.

The predisposing causes are fear, the fear of being afraid, terrifying experiences, want of sleep, cold, wet, and the appalling sights at the front. These emotional conditions, when extended over periods varying from days to weeks, produce irritability and loss of self-control; emotional disturbances lead to loss of sleep, and loss of sleep to more intense emotion. To this vicious circle are added the countless discomforts, both major and minor, incident to trench warfare. Even the suppression of emotions, which every good soldier cultivates, adds its contribution to that state of anxiety which predisposes him to the condition that we are now considering.

Lack of self-control makes some unhappy men positively unable to face the enemy, and the fear of being afraid is one of the predisposing causes of the type of neurasthenia not infrequently seen in those who have had no actual injury; indeed many patients have never been in the front lines. The stress of war conditions and more especially the effects of seeing and hearing high explosives, even without any injury, sometimes bring about a profoundly neurasthenic condition.

The neurasthenic of the hypochondriacal type is afflicted with introspection, is invariably a nuisance to himself, and generally to those who have to live with him. He is bad raw material for recruiting purposes. Temperamentally, he is unfit to be a soldier. His self-control is, and always has been, subnormal.

I have found from consideration of a large number of consecutive cases that the following are the most common symptoms: disorderly action of the heart, epileptiform seizures, tremors, functional stiffness and functional loss of power of muscles, loss of flesh, and loss of hearing and speech. From the mental or emotional side, we have subjective symptoms which, although sometimes intangible, are very real to the patient, such as mental lassitude, giddiness, nightmares, loss of self-control and confidence, loss of power of concentration and fear of closed or open spaces, nervousness, a vague feeling of apprehension, and, in the more acute stages, confusion of thought.

It is obvious that the origin of the conglomerate collection of symptoms which go to make up the content of neurasthenia is mental. That aphonia and deaf-mutism are accounted for by an abnormal control on the part of the unconscious mind over the speech centers is proved by the sudden and dramatic cures which sometimes take place, and by the fact that suggestion not infrequently cures these conditions.

It is apparent that morbid changes of a serious nature take place in the nervous system; but, inasmuch as most cases recover, an examination of the brain and spinal cord cannot be made to determine just what these changes are. It has been suggested that minute haemorrhages into nerve tissue take place, and the fact that cerebrospinal fluid has been found to be under increased pressure supports this view. A high explosive gives a pressure of ten tons to the square yard, and it is obvious that under such influence anything may happen.

Many neurasthenics are taught to be so self-centered and obsessed by self-pity and introspection that they unconsciously lay themselves open to the suspicion, by those who have no special medical knowledge, of being mentally afflicted. Nevertheless, neurasthenia and insanity are two totally distinct diseases. The one does not merge into the other, and if a man's case is diagnosed as neurasthenia and he subsequently becomes insane, an error in diagnosis has been made, and the early symptoms of insanity have been mistaken for neurasthenia. I think it is a matter of considerable practical importance in the interests of neurasthenics, especially of the severer types, that this should be clearly recognized.

The influence which the mind has upon the body is profound, and the following case which came under my observation some time ago may help those who have not thought much upon the subject to appreciate the fact:

B. T.'s temperature appeared to range between 97.4° and 103.4° F. When the doctor took the temperature in the morning, it was always normal or subnormal; the patient himself took it as often as six times in the day, waking occasionally in the middle of the night for this purpose. Neither the doctor nor a consultant who had been called in could form any opinion as to what was the matter with the patient. His blood was tested for typhoid. I found that if the doctor did not call each day he was sent for in a hurry—that the patient was very nervous and worried. His wife was hourly expecting her baby. There was only one bed in the house and I suspected that his anxiety to get well before the event was keeping up his temperature. I induced the doctor to take the thermometer from B. T. Upon calling subsequently once or twice in the afternoon, at which time the patient's temperature had usually been above normal, the doctor found it to be normal. From the time the thermometer was taken away there was a rapid and uninterrupted recovery!

The idea of illness and its possible consequences obsesses most neurasthenics. Their pains are real, but often only psychic; they are victimized by their unstable nervous systems and too often make no stand against morbid introspection. Their injuries seem to pervert their mental outlook, so that they persistently dwell upon them. They exaggerate all unusual sensations so that these in time come to occupy a large portion of their field of consciousness. The repeated rehearsals of the awful details of warfare revivify and accentuate the ill effects which were induced by their original injury. In many cases the idea that they will never recover becomes fixed, and has a baneful effect on the progress which should be made. Misplaced sympathy and unintelligent nursing frequently result in the manufacture of severe cases.

Normally when we reproduce impressions they are by no means so vivid as they were originally, but some brains can reproduce an impression so as almost to visualize it. The groups of thought run along the lines of least resistance, and each repetition leaves a path more easily trodden.

For many years I have been much impressed by the definite relationship which exists between the duration of an illness and the gradual loosening of the capacity for the work-habit. It must not be forgotten that the mental impression of invalidism, the result perhaps of months of thought, is a very real one to the patient. The only way to effect a cure is to convince him that he certainly will recover; indeed, in the case of the neurasthenic the whole environment *must* be one of confident assurance of complete recovery. He should have a continual succession of graded experiences arranged to push from his mind the delusive feeling of inability to work.

Now, please do not misunderstand me. Neurasthenia is not fraud, it is not malingering, it is not wicked self-deception, and, above all, it is *not* cowardice. It is a real disease. Neurasthenia is often found among men remarkable for their bravery, daring and initiative, men who have been dispatch bearers, snipers and leaders of forlorn hopes. Tried soldiers show the same symptoms as young recruits. Many of these soldiers are brave men, but they are temperamentally and neuro-potentially unfit for the awful work which they have volunteered to perform. That they are not cowards is shown by the fact that many men who have recovered are found a second time in the fighting line. These men say quite frankly that they do not want to go, but will do so if it is their duty. One almost doubts the sanity of men who know the horrors of war and *want* to go back. Their bravery consists in going when they do not want to. An attack of neurasthenia is no more a reflection upon a man's courage than is the presence of a bullet. Both bear witness to the fact that he has probably been in the thick of the fight.

If we at home could successfully tackle the problem of differentiating between who is and who is not a potential neurasthenic we should prevent wastage of the personnel in the fighting line, the lowering of the *morale* of the men in active service, and the denuding of the country of men useless in the field, yet capable of valuable work for the Army at home.

Most of the neurasthenics I have seen are suffering from concussion caused by high explosives and have had some commotion of the nervous system; but in most cases before they come under the care of medical men in this country they have recovered from the grosser pathological conditions, and we have to deal almost exclusively with the mental and emotional results of the concussion, which is, I assure you, no easy task. When recovery from the grave symptoms has taken place, there is too often left a legacy of functional disabilities which demand very special treatment and a carefully arranged environment. The chief condition met with is a perversion of the mental outlook, which requires psychological treatment. These men are emotional and impressionable, and their moods and even their methods of thought seem to be communicable. Fussiness over treatment and tenderly expressed sympathy only accentuate the trouble. Kindness combined with firmness, and a strong unswerving faith in ultimate recovery are the keynotes of success.

I lately came across a good example of how *not* to treat a neurasthenic. I received a report from a doctor at a well-known spa, to whom, not without some misgivings, I had sent a patient with a very mild form of neurasthenia produced by nothing more serious than a shock to his ambition. "He drank," said the doctor, "the thermal water activated with added radium; had the incandescent light followed by the static wave to the spine and foot, and some packs of mustard bran over the liver and stomach; and I gave him a purin-free dietary. I also made application of the electric cautery over the cervical ganglia of the sympathetics." I stopped this treatment, and sent the patient back to his work, which he has done continuously and well ever since. Spa treatment makes a neurasthenic concentrate his attention on himself.

One common type of functional nerve disease is a temporary paralysis of a group of muscles, resulting in loss of power of a limb or part of a limb. A very common form is drop-wrist; here, although the muscles and nerves are all perfectly healthy, the patient cannot raise his hand from the drooping position. Yet if a mild electric current is applied to the muscles which pull upon the wrist, they are found to act and to straighten out the wrist quite independently of the patient's will. Now, when a patient, who has been for months convinced that he has a true paralysis of his arm resulting in drop-wrist, has had it demonstrated to him that neither the muscles nor the nerves are really useless, and he sees that they do in fact actually contract under the electrical stimulus—that his drop-wrist is momentarily cured—the effect cannot fail to be beneficial. He is now convinced that he has no permanent organic disease, and even a dull man will appreciate that if he could but apply the necessary stimulus from his brain he would soon be well.

Functional disease is the result of a strange combination of what appears to be reality and unreality, for whilst everything is in good working order the motive power to start the machinery cannot, as it were, be switched on. Some of these cases are almost ludicrous; for instance, a man who complained of paralysis in his left leg admitted that his right was strong and healthy, and when asked to demonstrate his power of kicking out with the right did so most vigorously, unconscious at first of the fact that he was supporting himself on his left leg while he did so. I wish the functional nature of these cases might always be so easily demonstrated and the cure so easily effected.

The experience which has necessarily been gained from dealing with so many cases has led to a revision of the methods adopted in the early days of the war. At the end of 1916, the military authorities in France, in order to cope with the serious leakage of men from the front, decided to abandon the use of the terms "neurasthenia" and "shell shock" in official nomenclature, and to replace them by the terms "neurosis A" and "B," thus re-placing terms which had become too familiar to every soldier and rolled rather too glibly from the lay tongue. Any high explosive which bursts sufficiently close to a trench and hits the parapet throws earth over the man standing in the trench below. Many are, unfortunately, actually buried, and even those who have only part of their bodies covered are the subject of a certain amount of shock and are, for the time being, unable to "carry on," and come under the care of the medical officer at the Regimental Aid Post. It used to be the practice to pass such mild shell-shock cases down the line to the base and eventually to England. Now, regimental officers are given to understand by means of official printed instructions, that upon them devolves the task of encouraging men who are suffering from a temporarily jarred nervous system to pull themselves together and to get back as soon as possible to their regiment. "Hello, Smith, you have had a lucky escape, my lad. What? A bit shaky? That's the way it takes lots of fellows, but you will be all right in a day or two. There is really nothing wrong with you except that injury to your finger, and I'll soon fix it up for you." This is the necessary preventive, which the potential neurasthenic so urgently needs, and, thus applied, it is given just at the psychological moment. The man recognizes that his medical officer knows exactly what has happened; he knows also that if the medical officer says he is fit for duty he has to go back and make the best of it.

I am informed on good authority that nearly all the men dealt with in this way recover their stability very quickly and do well. But the proper cases in which to apply this treatment have to be very carefully selected. The severer types,—those who have been concussed,—many of whom are still unconscious, are obviously unfit to remain near the line, and, with the sanction in writing of the Assistant Director of Medical Service of the division to which he belongs, the man is transferred down the line to the Casualty Clearing Station, where he remains until his transfer to a special Shock Hospital is arranged for.

Neurological centers have been established both by the French and English War Departments immediately behind the fighting line. Here quick returns are the order of the day. The atmosphere in which the shell-shocked soldier is treated is second only in importance to the personality of those who are to treat him. In these front-line neurological centers the treatment is more intensive, but the feature which distinguishes it from those we employ at home is that the cases are taken, as it were, red-hot from the battlefield, and are moulded by the strong wills of those specially selected for their treatment. Frequently men are returned to the fighting line in two or three weeks. (Contrast this with the unfortunate experience of those who find themselves for a period extending to even twelve months in some eight or nine different hospitals, perhaps some of them V. A. D. Hospitals.)

There is a special Shock Hospital for each Army area. They are placed near the Clearing Hospitals, and are staffed by specially selected medical officers under the superintendence of a neurologist of repute. Here the case is thoroughly investigated, and if it is found that the man is not likely to recover soon he is sent to a Base Hospital, from which in time he may be transferred to England. Numbers of men treated at these special hospitals are found after one, two, or three weeks' treatment to have sufficiently recovered to be transferred to a local Convalescent Camp, where attention is specially paid to them as convalescent neurasthenics. Appropriate exercises are prescribed and, later on, football and competitive games of skill are encouraged.

In these special Shock Hospitals definite data of the reflex responses and other phenomena are being collected, and I think there is no doubt that when these are collated the information gained will be a valuable contribution toward a more accurate classification and prognosis of the cases.

I am given to understand that in the advanced stations for dealing with these functional conditions the percentages of cures are very high indeed, and that the duration of the conditions is remarkably short. An immense proportion of this class of case is curable. Failures depend upon the stubbornness, lack of will power, or refusal of further treatment by the patient.

Cases which are sent over from France and which are likely to require prolonged treatment are accommodated at one or other of the following hospitals: Red Cross Military Hospital, Maghull, Liverpool; Springfield War Hospital, Upper Tooting, London; Royal Victoria Hospital, Edinburgh; King George V Hospital, Dublin. Those cases which are not likely to require prolonged treatment are sent to the Neurological Centers of the Territorial Force General Hospital; the National Hospital for Paralysis and Epilepsy, Queen Square; the Hospital for Nervous Diseases, Maida Vale; or the West End Hospital for Diseases of the Nervous System, Welbeck Street, W.

Dejerine, Dubois, Babinski, and many other eminent neurologists, both in France and this country, have pointed out that practically the only treatment for the vast conglomeration of war neuroses grouped indiscriminately under the term shell shock, consists in getting the patients to appreciate that their fears are abnormal, and that their mental outlook is perverted, and in using all the means possible to prevent their aberrant fancies running along the lines of least resistance. The neurasthenic should be encouraged, as Dubois says, to make an "optimistic inventory of his mentality." Neurasthenics are amenable to reason, and generally repay the trouble expended on them and the effort made to get their thoughts to run along new and healthier lines. A thorough physical examination followed by a definite assurance that no organic disease is present is a good foundation for the cure of functional disease.

Re-education is the keynote of the treatment for shell shock. It is obvious that when a mental condition is such that it can be readily cured by being set in a right mould, it can as easily be set in a wrong mould; hence it is of the utmost importance that, from the very first, the case should be under the care of those who thoroughly understand the nature of the complaint. A healthy and invigorating environment is everything. There can be no general treatment *en masse*, each case demands individual attention. When dealing with forty or fifty cases, probably no two cases can be treated in exactly the same way.

No doctor or nurse is of any real value for the treatment of the neurasthenic unless he has confidence in himself and can commandeer the confidence of the patient. Infinite patience, common sense at every turn, and real but thoroughly disguised sympathy are essential in those who undertake the care of such cases. Massage, electricity, persuasion, occupation, light graduated work, fresh air, good, wholesome food, and above all a healthy outdoor environment, are essential adjuncts. The psychotherapeutic method of treatment has been found by experience to be wonderfully effective, *provided only it is in the right hands*. Nothing retards recovery so much as the flying visits of unthinking, but kindly intentioned, philanthropic lady visitors. Persuasive conversation should be systematically arranged for, in which the patient and doctor can have quiet talks, so that the man is led by tact and guarded sympathy to lay bare what is, as it were, in the back of his mind. Nothing in the nature of so-called psychoanalysis is necessary. It is the doctor's duty to find out what is worrying his patient, and what is keeping him from getting well, and this can be done without psychoanalysis.

My experience is that it is better that all patients should be isolated during the earlier part of their treatment. The calm restfulness of solitude has a peculiar effect in allaying irritability and, strange as it may appear, prevents morbid introspection. Isolation is not solitary confinement; a nurse is in frequent attendance. The short, initial stage of isolation enhances the value of the suggestion of rapid recovery practiced by the physician and nurses. Electrical treatment for these cases is of value, but the stoutest advocates of this method will not deny that the effect is intimately associated with the mysteriousness of the electric current. There is one proviso to make with regard to all treatment, and that is: Unless a patient desires to get well no treatment can cure him.

Personally, I have always believed that hard and continuous work is the only way to be really happy, and that work in one form or another is the only salvation for those who are suffering from functional nerve disease. I have preached this in season and out of season for a period of ten to fifteen years, and it is a great satisfaction to know that so high an authority as Major Mott has endorsed this view in his practice at the Maudsley Hospital.

In spite of the treatment afforded, and the large number of cures effected, it is obvious that a very appreciable number of men have been so incapacitated by shell shock and kindred nerve injuries that they are not fit for any further military service and receive their discharge. The Military Service (Review of Exemptions) Act does not extend to any officer or man who has left or been discharged from the service in consequence of neurasthenia or allied functional nerve disease, if it is certified by a Special Board to be the result of service in the present war.

A Special Medical Board, of which I have the honour to be President, was formed by the Director General to examine all discharged soldiers suffering from neurasthenia and functional nerve disease, with a view to awarding gratuities or recommending pensions. The Board has laid upon it, in addition, the duty of periodically re-examining all men in receipt of temporary pensions who have been discharged from the Army on account of functional nerve disease. The number of pensioners is now 160,000 to

170,000, the percentage of those suffering from functional nerve disease is roughly 20 per cent; the Board has, therefore, ample scope for its activities.

This Special Medical Board has never confined itself strictly to its official duties; whilst rigidly discharging the functions for which it was appointed, it has recognized the unique opportunities which it has of assisting in civil life those whose cure is not yet complete. For instance, a small remedial exercise room has been instituted at the headquarters of the Board, where many of the minor but more persistent functional disabilities are treated, by masseuses who are paid by the British Red Cross Society. Many men who are already at work, but who still require skilled treatment, are encouraged to come for half an hour or an hour daily. Here they are treated by the nurses and are seen periodically by members of the Board. The Ministry of Pensions not only pays their fares to and from the Board's premises, but refunds any loss of earnings which has been occasioned by absence from work for part of a day. In the case of men whose domestic circumstances have become disorganized and who seem to be incapable of adjusting them, or where men require temporary work in the country, a letter is written to the Local War Pensions Committee drawing attention to the case. Five hundred such letters have already been written. Many communications take place between the Board and hospitals, the men's own doctors, specialists, surgical appliance makers and employers. But, when all is done, there still is a large residuum who have not yet recovered, and are wholly unable to earn a livelihood, and who obviously cannot recover without very specialized treatment.

At the request of the Minister of Pensions I have undertaken the organization of Homes of Recovery in different parts of the country for the institutional treatment of ex-soldiers of this class. Two institutions, one accommodating 100 patients, and the other fifty, have been opened, one in London and the other in Belfast. Arrangements have also been made to open eight others: six in England (including one for officers), one in Wales, and one in Ireland.

The First Home of Recovery is a large building at Golders Green with a particularly cheerful outlook. It has accommodation for 130 people, of whom 105 are patients. The house is surrounded by fifteen acres of lawn and garden. The main wards have a southern aspect. By the generosity of the Joint

War Committees of the British Red Cross Society and Order of St. John, the Home has been efficiently equipped with all the necessary appliances which modern methods can suggest. It is intended to be the model upon which the future institutions will be based. The cost of maintenance of these institutions will be defrayed by the Ministry of Pensions.

The Golders Green Home is under the management of the Maida Vale Hospital for Nervous Diseases, and the hospital medical staff are the physicians in charge. An energetic and capable Resident Medical Officer has been appointed—a matter of the utmost importance, for the Resident Physician has to play the part of teacher, and it is his duty persistently to bring his personal influence to bear upon, and give individual care to, each patient.

The Travelling Units of the Special Medical Board visit military centers in all parts of the kingdom, and where there is necessity for similar institutions the fact is noted. A waiting list of prospective patients is compiled. When these lists justify the opening of other institutions they will be forthcoming.

How do these homes differ from ordinary hospitals? What special methods of treatment are employed which cannot be supplied elsewhere? There is nothing which these institutions can supply which could not be arranged for in the great neurological centers through which most of these men have passed, were we living in normal times and under ordinary conditions. The unfortunate exigencies of the present situation and the enormous output of functional nerve disease which daily reaches us from the front make it practically impossible for tedious cases of this sort to receive at these centers the individual attention which they require.

The somewhat bold experiment of aggregating considerable numbers of men suffering from functional nerve disease has been attended with success; it was at first to some extent an experiment.

The principal methods adopted in these remedial homes are:

1. An attempt to gain the confidence of the patient, and teach him to believe that he will recover, and continuous and painstaking efforts to persuade him to adopt an optimistic frame of mind.

2. The application of the usual remedial methods, such as massage and electricity.

3. Outdoor work and recreation.

The difference between the conditions of treatment at the Maudsley Hospital and the First Home of Recovery at Golders Green is that whilst in the former the patients are under military discipline, and know that if and when they recover they are liable for military service, at Golders Green they are all discharged men and we have no military authority over them. The men know that, having been discharged for neurasthenia, they cannot again be conscribed at any time during the present war. Our patients are not haunted by the thought that if cured they may be sent back to the fighting line. There is to be no Army discipline in the Homes of Recovery. These institutions are exclusively for civilians who have left the Army. Khaki is taboo. We encourage the men to appreciate that they have left the Army once and for all, and that they cannot be compelled to re-enter it against their will.

Generous terms have been granted by the Ministry of Pensions, so that all who enter the Home may know that their wives and families are amply provided for in their absence. The wife or dependent will be paid a weekly family allowance sufficient for maintenance without assistance from the patient whilst he is in the Home. Allowances for children will also be made. To those who desire to enter the Home the following amounts, therefore, will be assured:

Single Men

	£	s.	d.
Per week	1	7	6

An allowance will be made for dependents.

Married Men

	£	s.	d.
Per week	1	7	6
For wife	0	13	9
For first child	0	5	0
For second child	0	4	2
For third child	0	3	4
For each of the other children	0	2	6

A small deduction will be made from the man's allowance for his board, but the treatment will be provided without charge. Whilst the patient is in the Home the family allowance for wife and children will be paid to the wife or dependent; and in addition the full pension of 27s. 6d., less a small deduction for board, will be paid to the patient. As his personal expenses will be trifling, it should be possible for him to send a substantial additional weekly allotment to his wife and family, and he is encouraged to do this. The Home is in no sense a Military Hospital; no patient can be retained against his will.

The First Home of Recovery is in the nature of an ordinary convalescent home, but it differs from these institutions in that special treatment is actively carried on, and only a particular class of patient is accepted. The classes which we lay ourselves out for are men suffering from certain forms of paralysis, tremors, stammering, etc. We are hopeful that by the rapid cure of a few of the earlier and simpler cases we shall create in the institution an atmosphere of confidence and cheerfulness which will unconsciously influence the more difficult ones. In most of the cases, gloom and depression have become almost an obsession. Our hope is that the suggestion of a cheerful environment will gradually influence the trend of thought of these unfortunate men. After all, our conduct in life is largely the result of suggestion. Our idea is that cheerfulness shall be the prevailing atmosphere of these homes.

Any work which is interesting, capable of careful gradation, and conducted in the open air is admirably suitable for those recovering from neurasthenia. All these cases have already had too much so-called rest, which as a rule has merely been idleness combined with introspection. Intensive culture, as practiced by the French in their gardens round Paris, fulfills these requirements, and I had little difficulty in persuading the Ministry of Pensions that such a garden should be instituted at Golders Green. Major Fraser, who for twelve years has been the leading expert on this subject, has been engaged to superintend the garden. The work of intensive culture is not laborious, and provides full scope for the bodily and mental activities, and is a suitable and useful outlet for the activities of many of the men whom we hope to cure at Golders Green. The light work of the garden will constitute a part of the remedial treatment of the Home.

Many of these shell-shock cases have lost their situations, and in a large proportion of cases their pre-war, indoor occupations are unsuitable for them to return to, even if they could; they will require to change their occupations, and the changes must be from indoor to outdoor employment.

If the treatment is rapidly successful, the average stay in the Home will be short, and there will be little opportunity for the men to acquire a real working knowledge of intensive culture which would be of practical value to them after leaving the Home. We are, therefore, faced with this difficulty—that the more rapidly we cure our patients, the less real knowledge they will have of intensive gardening; but under the training scheme of the Ministry of Pensions men who are discharged from the Home as cured may, if they care to live in the neighbourhood of the Home, attend daily as learners, during which time they will be paid by the Ministry 27s. 6d. a week, and will in addition have put to their credit the sum of 5s. per week, which sum will be handed to them at the expiry of a six months' training.

The Ministry of Agriculture has promised to send instructors in the winter evenings to assist the men by informal talks of a very practical nature upon agricultural matters. I am hopeful, therefore, that not only will an impetus be given to intensive culture throughout the country, but many men whose nervous breakdown has made it impossible for them to return to indoor occupations will have prepared themselves, as the result of their residence at Golders Green and the subsequent training course, to make a living under circumstances in which they will best be able to maintain their health. The interesting work and occupation of the garden is not the only feature of the scheme. Carpenters', iron workers' and basket makers' shops are attached to the main building, where the rough frames, packing crates, tool handles, and the special mats for covering the glass frames will be made bythe men.

The success of this experiment for the treatment of those suffering from functional nerve disease depends, I believe, largely upon a few fundamental principles, which I have determined shall be strictly adhered to in every institution under my care:

1. No doctor, sister, or nurse who is not an optimistic and enthusiastic believer in the methods is, under any circumstances, to be employed. If any such is found after trial to be inefficient, even if specially selected, he or she must at once be replaced.

2. Any patient who is making no progress will not be allowed to stay; he will be cared for elsewhere. The one unforgivable sin in a Home of Recovery is marking time.

3. The atmosphere of the Home must be one of hope. If cheerfulness and industry do not meet one at every turn, the administration is seriously defective and must lead to failure.

4. If, from the incompetency of those responsible, the atmosphere of one of these Homes has become vitiated, and the men are found idly lounging against the walls, if the gramophone takes the place of heart-to-heart consultations with the doctor, if long joy rides relieve the staff of its duties, then radical changes must follow.

5. No one must be overworked. To allow the resident doctor (on whom really depends the success, or otherwise, of the whole scheme) to become tired, worried, and stale would be a fatal error. In these times of stress one must not be too particular, and lay down rules as to how many patients a doctor can serve faithfully. This depends upon the personality of the doctor, the nursing staff which assists him, and very largely upon the atmosphere which he has created. Whether additions are required to the medical and nursing staff can only be determined by actual experiment, but these will be ungrudgingly supplied if asked for. My view is that if a good resident medical officer has been secured, provided he is successful, the less he is interfered with the better. This is the attitude which, as one of the physicians to Maida Vale Hospital, I purpose to adopt toward the First Home of Recovery.

The medical profession and the country have recognized the necessity for giving of our best to these unfortunate sufferers from nerve strain. The work is particularly difficult, but perhaps there is no class of patient who better repays us for the skill and care expended. I am confident in the hope that hundreds of men now in the grip of a most distressing disorder may yet be fitted for a life of usefulness and productivity.

Such is the scheme for the salvation, by work, of the neurasthenic. To those who consider it utopian, and who from politeness suppress their smiles of incredulity, I would say that the scheme has enlisted the co-operation of many of the best brains and the hardest workers of the country, and it is backed by the sympathy and co-operation of a great department of State.

LIEUTENANT-COLONEL ALDREN TURNER'S REMARKS

Lieutenant-Colonel Aldren Turner, C.B., M.D., spoke upon the principles of the management of the shell-shocked and neurasthenic soldiers in the special military hospitals. These principles were laid down early in the war, but they were subject to modification as our knowledge of these patients and of their disabilities became better known and understood.

The first principle is *segregation*. For the most part the neurasthenic soldiers have been treated in institutions specially set apart for the purpose, under the care of medical officers specially qualified to treat them. The adverse criticisms brought forward in opposition to segregation in the early months of the war have not been justified. On the contrary, its usefulness has been strengthened and extended by experience. These patients do not imitate, nor in other ways react harmfully upon, one another. Moreover, it has been found that when placed in the general wards of a hospital, the sufferer from shell shock not infrequently is the butt of the other patients, who are unsympathetic and disposed to regard as trivial the tremors, stuttering speech, unnatural gait or other symptoms which characterize so many cases of shell shock. The admixture of these patients, as has been suggested, with cheery companions, suffering from non-nervous disabilities, might even be undesirable, and is certainly unnecessary.

The second principle is to give the medical officers liberty to treat their neurasthenic patients along such lines as they consider desirable, and which experience has shown to be of therapeutic value. There is no disorder to which the axiom "treat the patient and not the disease" applies with greater directness than to neurasthenia. This liberty of action is very necessary in view of the different types of neuroses and psychoses which are admitted to the special military hospitals under the guise of shell shock. Cases of exhaustion require rest in bed; paralytic cases require exercise and re-education of the movements of the paralyzed limbs. The simpler forms of anxiety need reassuring and explanation of the origin of their fears. The terrifying dreams which disturb the sleep of so many men suffering from shell shock must be analyzed and explained. The dreads and fears, delusions and hallucinations, and other morbid ideas must be searched, investigated and understood. After this, the re-education and readjustment of the patient's mental outlook toward his symptoms must be taken in hand.

It has been found that a too constant and too frequent use of massage, of electrical applications, of baths and of the other physical methods of treatment assiduously practised at the spas, tend to accentuate rather than relieve the condition for which they are used.

The third principle is *occupation*. Quite a number of cases of war neurasthenia and genuine shell shock in the early stages derive great benefit from a "rest cure," but it has become increasingly obvious, with more experience and knowledge of these cases and of their causes, that rest and isolation have only a limited application. The best results are obtained by a judicious combination of suitable psychotherapy and occupation, mainly of an outdoor kind. It is useless to attempt to cure by work alone a man whose mind is depressed by anxiety and forebodings attributable to circumstances which he does not understand; but if by judiciously selected work and carefully regulated outdoor occupation, his sleeplessness is mitigated and his circulation and general nutrition improved, the value of the mental therapeutics is enhanced and supplemented.

The fourth principle is *compensation.* It was recognized early in the war that a large number of soldiers, who suffered from shell shock and neurasthenia, would be unfit to return to military duty, although their ability to carry on their civilian work after discharge would not be more than temporarily impaired. As it had been recognized for a long time that some forms of nervous disability were prone to exaggeration or might even be made chronic by undue consideration, it was determined that nothing should be done by the payment of pensions which would retard or prevent the recovery of soldiers who had become disabled through a nervous breakdown. It was thought, therefore, to be desirable to recommend the granting of a money bonus, in place of a pension, to selected cases of neurasthenia and functional nervous disorder occurring amongst soldiers when hospital treatment should be no longer necessary, and the patient unlikely to be fit for further military service. To carry out this selection and to assess as far as possible the money value of the disability, a special Medical Board was appointed under the presidency of Sir John Collie. The gratuity is paid to the soldier as soon as he leaves the military hospital to return to civilian life. Cases of neurasthenia who are unable to return to civilian work on discharge from a military hospital are passed also through this Board, which recommends a temporary pension or, if desirable, further treatment in an institution for after-care. By these means it is hoped to establish continuity between the military hospital and the after-care arrangements.

MENTAL HEALTH FOR NORMAL CHILDREN

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THE simple principles of mental hygiene are sometimes neglected because so familiar; but they are as important as they are commonplace, since for the most part they are based both on world-old experience and on scientific study. They should be practiced in every home, and heeded in all forms of school instruction and discipline. Among the most important of them are the following:

(1) Children should be given opportunity for normal reaction to their natural instincts and impulses—to be active in play and work, to sleep at need, to express their emotions, not only to assert themselves, but to serve others and co-operate with them. Function, response to stimulation, action, work, represent the first conditions of mental as well as physical health.

(2) Children should be trained to control their activities and impulses. Natural and helpful control is not by repression and direct inhibition, but rather by indirect control. We control one muscle by contracting an antagonistic muscle; we control one action by doing something else, one interest by developing other interests; we stop thinking of one thing by thinking of something else. Repression means a short circuiting of the nervous reaction and the dissipation of energy within the nervous system itself, instead of normal expression in co-ordinated activity. Control means the utilization of the nervous energy in developing a new and healthful form of activity that may take the place of the unwholesome activity. Every interest is potentially a means of self-control.

(3) Children should be taught to concentrate attention on the one thing in hand. Children naturally do this. When the school attempts to transfer their attention from their spontaneous interests to the more artificial scholastic interests, care should be taken not to weaken the natural habit of concentrated attention. Short periods, complete attention, no dawdling, should be the rule. While developing the power to work for more distant ends, attention should usually be focussed upon the present situation;

and in the moral and emotional training children should be taught to live one day at a time, to settle their moral accounts every night, never to hold a grudge, never to let the sun go down upon their wrath, to look upon each morning as a new day in which to improve, but not to carry over their troubles from yesterday.

(4) Attention to the present situation implies orderly association, the next condition of efficiency and mental health. But in all subjects and all methods of instruction and training care should be taken to avoid all confusion and interference of association. Disorderly association means the beginning of mental conflict and worry. Tasks should be simple and definite, instructions clear and concrete, decisions and actions straightforward and whole-hearted. Thus habits of orderly association are developed.

(5) The fifth condition of mental health is an active attitude in the face of difficulties. The trying situations of childhood, "when a feller needs a friend," the occasions of worry, of fear, and rage, represent opportunity for the most important training. The physiology of these emotions indicates the hygienic response. An increased secretion of adrenalin into the blood serves as an emergency call; and all the energies are mobilized for action; an increase in the heart rate, an increase in blood pressure, an increase in sugar secreted from the liver, the stopping of digestion,—as a process of secondary importance that can wait for the time being,—are some of the emergency provisions. Everything is prepared for action. Vigorous action is normal. The repression of action probably means short circuiting and nervous strain. Normal activity for a child on occasion of fear, for example, may be to run away from the object of emotion or to attack it. The latter is morally better and usually safer and more healthful. By attempting always to do the best thing in a difficult situation, a habit of the utmost importance for the mental health is soon developed.

(6) The sixth condition of mental hygiene concerns normal social relations. It is better for a child's mental health to eat and play and work and study with other children than alone or merely with adults. To act with others as follower or leader, to serve, to co-operate, on occasion to resent, or to fight, represent healthful attitudes and healthful forms of activity; to deceive, to act cruelly, to be suspicious, to hold a grudge, represent unhealthful as well as unsocial mental attitudes. The only child in

a family, and others who have lacked opportunity for social development, should be given special training.

(7) The seventh condition of healthful mental activity is a normal sense of dependence. This is perhaps the essential psychological element in religion—a sense of dependence on a Supreme Being, or on the beneficent laws and forces of nature, or on the moral strength of humanity, or the categorical undebatable authority of duty, or one's sense of honor, absolute and worth while for its own sake. If not tampered with, this seems to develop normally in children; first as dependence on one's own parents, later as dependence on something higher. The adult's duty in regard to this activity is chiefly negative—never to cast any reflections upon the parent, or the child's religion, or sense of duty or honor, this sacred shrine of the child's moral life; never to ask a child to act contrary to his conscience or to do a thing contrary to his sense of honor.

Such are some of the fundamental teachings of mental hygiene. We attempt to give the feebleminded and the mentally disordered the benefit of them. We should not deprive normal children of the same mental training.

To state these principles is easy, to practice them infinitely difficult, and, to train children to practice them, a task for the greatest artist. For a teacher to do this, demands more than constant care and effort; it requires constant self-repression; for healthful mental and moral fiber is built up by a child's own effort, not by the activity of adults. It requires suggestion on the part of the latter rather than demonstration, example rather than exhortation, sympathetic guidance rather than blame, and in general, training rather than talk.

The child who has normal habits of reaction to his impulses and feelings, who has many interests and the power of self-control furnished by them, the ability to concentrate attention on the present, habits of orderly association, the active attitude in the face of difficulty, a steadfast purpose for service and co-operation, and a sense of dependence and unsullied honor, is not only sane, but prepared for happiness, efficiency, and mental health.

All this represents the positive side. If, on the negative side the obviously bad habits and unwholesome complexes of association are avoided, with reasonable care for proper alternation of work and rest, and sleep and normal hygiene in general, we have the conditions for the development of the mental health. These conditions can be ensured only by the co-operation of the home and the school; and it is vitally important that parents take care that habits of health, in eating, activity and sleep, be developed in the home.

A CONSIDERATION OF CONDUCT DISORDERS IN THE FEEBLEMINDED*

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IT is customary for most of us to think of the problem of feeblemindedness in the gross, as composed of a group of so many dull, stupid, and incompetent children who are all either potential criminals, or are potentially good children who need segregation only, and that if they were properly housed and cared for, the life task for such children would be met for all time.

Now we all know that however energetic and benevolent the state may be, a large group of feebleminded children will be "in our midst" for many years to come, especially the high-grade type that usually masquerades under the behavior disorders of truancy, incorrigibility, or offenses against property and person in society at large.

Having the foregoing idea in mind, a group of us offered our services to the New York City Board of Education to act in an advisory capacity to help solve some of these by-product and benign problems in connection with the public school work. Personally I have had occasion to see many clinic cases of disorders of conduct in the feebleminded in which the issue was plain and the query was: What are we to do about it? After a little investigation of individual cases, the diagnosis of feeblemindedness in the pupils was obvious enough, but simple recognition of it was not sufficient to make possible a continuance of such pupils in the school group. Something more was necessary. It was soon obvious that for ordinary purposes the removal of such feebleminded pupils from the regular school and placing them in the ungraded classes was not sufficient. Conduct disorders have to be met upon the plane of their real defect—that of adaptation to the social life of the home, the school, and society in general. The principles governing the management of behavior disorders in the feebleminded are much the same as though the children were not feebleminded, but the interest-appeal and type of adjustment must be more precise and longer sustained.

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The high-grade feebleminded usually break down in studies which require the most abstract reasoning. Arithmetic is that study *par excellence*, while geography and spelling, requiring a visualized memory, are very nearly as bad as mathematics. At the outset, expert mathematicians in the form of visiting teachers should go from school to school and pick out the beginners who lag, and put a short time of expert training on these pupils and conserve them from despair—for that is what inability to keep up with the class means to these slightly retarded pupils. This expert working force need not be large, for there are few teachers specially gifted in making the subject of mathematics real and vivid to the pupil who possesses a concrete mind. The slightly retarded need this expert attention, and without it their soul despair is quickly converted into all sorts of pathologic traits, irritability, sullenness, truancy, incorrigibility and like disorders of conduct. No one presupposes that one may take these slightly retarded or high-grade feebleminded children from the group of dull pupils and make brilliant scholars of them, but by special expert tutoring one may enable many of them to make the grade of "working papers"—the great desideratum of the public school system to-day—besides conserving such pupils from the conduct-disorder group, where a whole new system of special care may be necessary. The issue is comparable to the conservation work going on everywhere to save incipient criminals from the long, painful and costly road of crime. The higher grades of feebleminded and simply retarded pupils in private schools have long since been given this special tutoring, and why should not the public school adopt some such methods?

The foregoing, then, is the first real impingement in the progress of the high-grade feebleminded pupil; and, as though this were not enough to break down his naturally weak resistance to temptation, we find the average home of the pupil of this type is what it should not be. Often belonging to a large family, where the hardiest members get first attention, even in the home the backward child feels the keen competition for preferment, if he is not suffering from some physical handicap which silently pleads and gains for him the family pity and special attention. His very dullness which makes him often the object of merciless grind in school, makes it well nigh impossible for him to get help from some member of the family itself, often fearfully handicapped economically. Tired and disheartened from long hours of work, the older sister, brother, or parent is no fit teacher for the backward and discouraged pupil. Thus neglected he seeks the easiest way out, and gains respite from his despair by questionable companionship with vicious-minded youths who are seeking such as he for idle exploitation. Thus he soon looks for comfort and entertainment outside the home and becomes a member of a gang or other antisocial group marauding the city streets.

What remedy may we urge for the delinquency of the home in the case of the mildly feebleminded, delinquent child? Until there are some satisfactory measures of curbing human passions, or gaining birth control with all the possible evils trooping in its train, we must supplement the home management by better discipline and urge a solicitous system of extra care for the backward child on the part of the different members of the family. It is astonishing how much can be done in such cases by simple, kind, common-sense talks with the parents, who, as a rule, are neither neglectful nor cruel when they once come to understand. They are often the first to ameliorate the physical and mental torture of these slightly retarded and backward children when they understand—when they find it is boredom or despair that these children experience, and not really original sin that lies at the bottom of their conduct disorders.

Supposing neither the home nor the school can, or does, meet the character faults such children exhibit—what then?

Through many years of experience, far-seeing citizens have learned that character defects shown in conduct disorders are met only by sidetracking and directing the overflow of energy into sluiceways of recreation and sport that are compatible with health and happiness. These backward and feebleminded delinquent children demand just this sort of stimulation to correct their bad habits. There can be *no direct suppression* of the gangsters, either of adult or of child type, which will prove a lasting and satisfactory success. We must build up something just as good to offset the vicious outlet furnished by the gang. If we be a Christian people, we ought to have the courage to try out the overcoming of evil with good, particularly when by so doing there is both a practical and an economic gain.

I have never seen a delinquent, feebleminded child of what I call the benign type whose conduct disorder was not done away with by correcting the school training, and the home and social environment. By benign, I mean one who has no essential inborn defect of instincts, and there are more than three fourths of this group even in the worst types I have had to pass upon. This is the hopeful message I am able to bring to you with my experience in handling this group. Most often the feebleminded delinquent only slowly and finally retaliates upon us for the long list of wrongs we visit upon him, and my plea is for us in all fairness to make a new effort to understand him.

I shall now briefly cite a few illustrative cases to show what the faults are and how we make an attempt to overcome them. Unfortunately our follow-up records are not yet as carefully looked after as we should like. The Board of Education is so burdened with providing for its many duties that it has been able to provide but a fraction of the funds necessary to carry on the work for the feebleminded and the psychopathic children in the schools.

The first case is that of a girl of eleven years, who, because of her inability to progress in arithmetic, had been left behind until she was classed with those of about eight years of age. She cut teeth at one year, and talked and walked only when nearly two years old. When she first entered school she studied well but after a time, when she saw she could not do her arithmetic, she "soldiered" a good deal. She was reported as being lazy and indifferent. She did all handiwork well, and was efficient in the things in which she took a keen interest. After a time she began to be rather sly and was inclined to keep away from her playmates. She then became sullen and depressed, slept poorly, looked pale, had headaches and seemed on the verge of nervous prostration. At home her family spoke nothing but German; they could not help her in her school work and she became depressed and morose. In the examination at the clinic she answered well, and expressed a lively desire to go to work where she could make good. Her parents were encouraged to get some of their English neighbors to help this girl with mathematics; the school gave her special tutoring for a month. She lost all of her neurotic symptoms and gradually got on quite well and managed, though a slightly subgrade pupil, to keep up in school fairly satisfactorily. In this case, the school and the home quite easily conserved this girl from a nervous breakdown from a too arduous task imposed upon a slow and mild type of arrested development. She is still kept under observation and will be encouraged to get no more schooling than will be necessary to make her a capable handworker in some trade for which she already has a fancy.

The second case is that of a thirteen-year old girl with a mental age of ten years by the Binet scale. She stole, lied, and was incorrigible at home and at school. It was found that she realized that her conduct was bad. The teacher was over-strict, the home was very wretched, and little attention was paid to the girl except to punish and reprove her. In a precise analysis it was found that she did her work poorly because she was held to a too severe discipline by an unsympathetic teacher and by parents who repressed her solely. Another school with more physical activity was supplied; the home atmosphere was modified, and she joined a girls' club where the honor system was in force. After three months she showed good signs of continuing improvement, and she has steadily improved during the two years' observation. She is too impetuous and flighty in makeup to become a thorough and patient scholar, and she will be encouraged to take up some sort of shop work as soon as she gets her working papers.

The third case is that of a boy of fourteen, who, though he Binéted to seven years, in practical tests showed a primary mental endowment nearly equal to his actual age. He cannot spell the simplest words, and does not know the three-times-table in multiplication. His sense training in the school was but fair. He was especially quick to respond at command in imitation of all physical training. His handwriting was shaky and much of his industrial training was accompanied by trembling movements. He spoke well. His reading was 2A, and arithmetic 2B. The amount of general information was fair. His power of attention and memory were good. In the ungraded class he did good manual labor.

The family history was negative, and threw no light on the causes of his mental defect. An inquiry into the personal history was negative aside from an attack of scarlet fever at three years of age. A year after the fever, which was moderately severe, he had two or three peculiar fainting turns which pointed to a certain type of epileptic fits, but nothing similar to them has occurred since. He is a robust, fine-looking, bright boy, with no apparent physical or nervous disorder.

Careful testing shows his intellectual development to be that of a boy of seven. He stands in great terror of his father and the teachers, who think he is lazy and unwilling to learn. At home he read his lessons over and over again before the father came home at night, so that the father would not hear his mistakes and scold him, but he continued to make mistakes in spite of all efforts. The main examination shows that he has a good disposition. He went through all the manual and motor tests easily and well; it was found that ever since the attack of scarlet fever he had been sluggish and indifferent to any kind of work requiring visual memory. He had always been poorest in spelling. His motor cleverness and ability to handle and understand mechanical work was well shown in an incident while in the country on a vacation. He wanted to take apart two broken bicycles and make one good one out of the remnants; after days of labor and much constructive adaptation, he succeeded in accomplishing the task in spite of being told that it could not be done. It was found that he had gradually become a timid type of boy and never played freely or naturally with other children, and preferred to be alone. He was interested in electrical work and attended to the electric bells in his home, and in fact did all the repair jobs about the house. He was employed at all sorts of work by the teachers in his school. His very lack of getting on at school seemed to have engendered a shyness, timidity, and feeling of inadequacy and doubt, which in turn were slowly shutting him out of daily friendly contact with the outside world. He was becoming morose and solitary in habits. What the boy himself had to say is as follows:

"I don't know why I can't get on at school; I can't spell, nor write, nor do arithmetic. I can do any sort of handwork; I seem to understand that by nature, but I can't carry anything in my mind. I mean I can't see a thing in the shop window and go home and make any part of a toy or machine by just having seen it in the shop. I want to be an electrician but realize I must know more about books if I am to do any good work in life. If I could get an education through my hands it would be easy."

We see here a boy of fourteen who is unable to make any progress in school work beyond the fifth year, owing to the fact that he has a rather poor auditory memory and practically no visual memory. On the other hand, he is able to do many kinds of manual labor, even of difficult technique, in advance of a boy of his age. He is a bright, intelligent, and neat-appearing boy. Intellectually he is not feebleminded, as he has a fairly well-elaborated mind in many if not all of the essentials of the rational use of his faculties. Undoubtedly the scarlet fever had something to do with the signal cutting out of the visual memory. Just what happened at that period we cannot say at this time. The plain duty before us is to recognize that modern civilization places heavier visual memory demands upon us as life grows more complex.

Frankly and in brief, what are we to do for the poor visual-memorists represented by this boy, for the problem passes beyond the welfare of this individual boy to that of a large group. First, we must know more definitely what the audist and visualist types mean as regard mental development and useful work in the world. We must know what specific appeals may be made to help the weakened avenues of the sense impulses in development. Until these studies are completed, on which some of our group are now at work, we have recommended that this boy be given special motor and trade training with which ordinary school studies may be concretely added as a part of such motor work. Working under this plan, he is now more satisfied and is advancing in the acquirement of mental knowledge.

Now and then we come upon boys who are not only retarded, but are difficult to manage both at home and at school, and who pass beyond all ordinary conventional means of discipline but who do well under a routine similar to that of the George Junior Republic. They usually express a keen desire to take up their life work at the earliest possible date in order to make money and be able to engage in sports and other amusements. They want to become boy apprentices like others older than themselves. The school authorities are trying to find some way to continue school instruction while these boys are really apprenticed. If this is not done, we may be quite sure that such boys will continue to show more open revolt as they grow older and become either occasional offenders against society or hardened to a life of dilapidation and crime. The following is a case in point.

Case IV is a boy aged eight years physically, but many more than this in worldly wisdom. In the school he was classed as a nervous and inattentive pupil. He liked drawing and was good in arithmetic, writing, and spelling. The teacher thought that on the whole this boy was bright and quick, but he was very dull and slow in the things he did not care to do. The teacher reports that the boy is very nervous, and the boy thinks that the teacher is.

The mother died of tuberculosis when the boy was two and a half years old. The father is temperate; the grandmother, with whom the boy lives, thinks the father's disposition is rather bad and stubborn, and she is therefore taking charge of the child.

The boy was normal in development after one year of age, when he recovered from marasmus. He learned easily, always kept up with his classes, and went as far as 2A. After acquiring this grade, he became inattentive. He has very good sense in regard to ordinary duties, uses tools well, chops wood, and is very active in running errands. He is naturally talkative, likes animals, is not especially obedient at home and resents being scolded and corrected. He seems naturally to pick out bad boys as being more interesting, and sets them up as his ideal. His grandmother thinks he is sly, and that he confides in his boy associates and not in her. He is not particularly truthful and is likely to find some way to secure his ends and do what he likes. On this superficial background of bad deportment and conduct, we shall now see what the boy's own story is:

"I don't like school as it is run; it is not as interesting as many other things. There is not enough to do. There are lots of other boys who do not like school any better than I do. I just go there and behave as I see fit. When they correct me, I tell them to mind their own business, and then if they punish me, I play truant. I like the boys very much and they like me. I do not like my home; it is so dull; they keep saying 'don't' to me all the time. My special friend is Tony; he is the head of the gang; we have a den and we get things from the 'ginny' at the corner. Some boy goes in and buys something in the shop and we take things off the stand outside. We only take things to eat; we get bananas, candy, and onions. We take bread and cakes from the little boys and girls who are sent to the baker's. We take all these things to the den and there have a good time. (With righteous indignation:) No, we never steal money; of course, we take pennies from the small boys who are sent on errands. When the cops chase us, we run out on the rafts and if necessary we go in the river. We know lots of places to hide away from the cops. I am second to the leader in the gang; they call me Henny Penny. We have had some good fights with other gangs, and get bruised up considerably, but we come out best on the whole. The boys who do not get any money at home and are not allowed to do errands to earn it, always steal it from their parents—how else are we to have any fun? Granny doesn't like me to be with these boys and she thinks they are bad company for me. I have belonged to the gang about six months now. I hope to be leader some day."

From the foregoing we see a retarded boy who now revolts from the ordinary type of school and the home restrictions, with a certain desire in consequence for vagabondage. There can be no doubt that such boys must have a life of work and school that shall have more color. They must join some boys' club that shall make for a proper mind-discipline by the boy group, for, as you see, he thinks highly of what the boys really want him to do, and will hold to such attention, but not to the forced discipline of elders.

Case V is a boy of fifteen who Binéted to nine years. He is mentally retarded and might be classed as a high-grade moron. He is of Russian extraction, and there are seven children in the family. The home consists of three very disorderly rooms. This boy has been in an ungraded class for two years; his attention and memory are poor and he can do nothing in reading; physical training and number work are poor. He is irregular in attendance and plays truant; he smokes and uses vile language. He is sullen in behavior, seems unable to sit still, and is slovenly in his habits, giving the appearance of being poorly fed and neglected. The mother cannot understand why the boy has been placed in an ungraded class, as he appears to her as being bright. The only fault she can find with him is that he does not learn quickly. His younger brother tries to help him with his studies at home, but he does not seem to make progress. He does not like his teacher and wants to leave school and go to work. He is self-reliant but easily led, and if he does anything wrong he tries to lie out of it. He is cheerful and affectionate at home, but shows keen disappointment and grouchiness if not allowed to have his own way, and becomes cast down if his mother will not allow him to dress up in his best suit. The mother thinks it would be best for him to go to work, as he does not learn anything in school, and she thinks if his father was able to get along without an education, this boy can do likewise. The father can speak very little English and cannot write at all.

At the examination this boy said: "I am a good boy in school and I have no trouble there, except when I play hookey. The days I play hookey I work and make some money so that I can go to the movies. I do not like school and fool around a good deal so they won't make me go to school. I want to go to work. I like baseball and do not belong to any gangs."

Here is a boy who cannot make the grade, but if we could find handwork and school training to go together he would do well. Possibly, with the ungraded class system, associated with a group like himself, he could safely be encouraged to work as a skilled hand-worker.

Case VI is a boy of fourteen years who reached the grade of 7B but repeatedly failed to advance and stayed in this class five terms. He was a bully among the smaller boys, was incorrigible and restless. When warned to behave better in school, he directed his attention to his studies and did better for a week, and then fell back into his usual careless and inattentive ways. His parents are German and the home conditions are fair, as the mother devotes her time to looking after the household. He fights with his older brother, and teases his sisters. The boy tells his story as follows:

"The boys tell on me because they are not friendly. I just touched a boy, and when the teacher asked the boy what was the matter he said I pinched him and was going to hit him when I got outside. Another boy told the teacher that I always hollered 'Forward' in the line. I did it only once or twice. Nothing else happened in school. I didn't hit the boy outside; I just made him run. He is smaller and younger. I can fight square and fair with boys my own size. Sometimes I would misunderstand the teacher and tell her I was right when she said I was wrong. If people are all right with me I am all right with them. I had a fight with my brother because he cut my bicycle tire; to get square I hit him in the face and then ran away. I don't like school; probably I'd like to be a fireman. I like fractions, but I am not good in arithmetic because I hate long division. I am not good in geography. I like reading and drawing maps. We have no manual work at school and I don't care much about tools. I have read *Uncle Tom's Cabin*, and *Huckleberry Finn*. They are pretty fair. I like to be out with the boys and play baseball and get on all right with them. Both my mother and my father whip me, but I don't mind; they use a rope and it doesn't hurt much. My mother is pretty good to me."

A general, simple talk and explanation of this boy's difficulties in the school and at home resulted in much better co-operation and understanding, which relieved many of the conduct disorders from which this boy had suffered in consequence of his inability to make proper progress in the ungraded class system.

From the foregoing fragmentary remarks, one is made irresistibly aware that the whole problem of feeblemindedness is not summarized or schematized in saying that we know the cause of it is heredity, nor that it is due to frankly defective glandular function in the body. So far as we could ascertain, none of the foregoing cases had a feebleminded ancestry, nor did they have a physical makeup any different from the average. We shall never arrive at any proper understanding of the causes and prevention of feeblemindedness until we reconcentrate ourselves anew to the individual case studies and make them thorough and detailed and see where they lead us, instead of studying this class *en masse,* which has been the popular mode of late. Simple common sense will help us greatly in this work, and we must not neglect the plain and obvious facts for glittering generalities in the abstract. The main purpose of this paper is to show that we are dealing with an enormously complex human problem, and any attempt to schematize human beings into a specific formula will always be foiled by facts. Psychopathic traits, or, better, conduct disorders in the mentally-retarded and arrested children, need to be considered and studied on the broad plane of our present-day knowledge of personality and psychiatry but above all, in doing so, let us do it simply and with good ordinary common sense, and I am sure we will gain the cheerful co-operation of the parents, the school, and society at large.

To summarize, in brief: We find that this group of feebleminded children needs special help in its school work in order to keep from lagging behind, and this should be given by a small group of expert teachers at the very beginning, as a timely treatment to keep the children from lapsing into a state of despair at their inability to keep up with the class. Both the school and the home should co-operate in the task of adjusting these children so that they will gain the proper outlets for their activities, which would otherwise seek channels of antisocial behavior and conduct. In addition, considerable utilization of neighborhood settlements and boys' and girls' clubs should be made, to supplement the stilted home environment, to overcome the tendency such children have toward associating with vicious companions, and particularly in regard to the boys joining gangs and seeking companions with antisocial tendencies.

FEEBLEMINDEDNESS AND INDUSTRIAL RELATIONS*

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ONE of the principal phases of the problem of feeblemindedness is the relation of the defective individual to industry. What can the mental defective do? What are the results of his attempts to compete with normal individuals? What conditions are most favorable for his maximum industrial production? Without doubt, these are questions deserving careful attention. Let us approach the subject from two different angles, considering first, the feebleminded individual within the institution, and second, the feebleminded individual at large in the community. In the case of the former, the mental defect has been recognized and a favorable environment has been provided, but the individual at large, with his deficient mentality undetected, is obliged to contend with those better equipped than himself and almost always fails to meet the industrial adjustment possible for those under direct supervision.

Within an institution for the feebleminded, we generally find three distinct types of defectives, namely, the very low-grade feebleminded case, commonly called the "idiot," the slightly higher type, designated as the "imbecile," and the still higher class, usually known as the "moron." In our consideration of industrial relations, we are not here concerned with the idiot, since he is either entirely untrainable or so defective in motor control that he cannot be made useful and must remain forever a dependent. The other two types can almost always be trained for work, unless there is a physical impediment. As Dr. Walter E. Fernald says, the low-grade feebleminded can be trained, even if only to carry objects from one place to another, and as an illustration he describes the manner in which a boy with poorly developed mentality may be taught to carry stones from one pile to another pile:

"A stone is placed in the unwilling hands of the boy, his fingers are closed around it, he is led to the second pile, his clasp is relaxed, and the stone allowed to drop. In company with other boys, this is repeated the next day, and the next, until finally, assisted by the faculty of imitation, the boy learns to pick up a stone and drop it in a given place of his own accord. . . . If he proves sufficiently teachable, his capacity for motor response is turned to practical account. Instead of picking up the stone from the formal pile, he is sent off into the fields, where he assists in cleaning the rough land, or is taught to use the grub hoe, to dig potatoes, to plant corn, etc." [1]

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* Read at New York University, February 23, 1917.

On account of the lack of development in the more complex mental processes, as, for instance, reasoning and judgment, motor training is generally adopted in the education of defectives. Although verbal instructions usually make little impression on defectives, they are easily stimulated if shown how to perform an act and their response is, as a rule, quick and fairly satisfactory. By employing motor training, which is based entirely on the imitative response, it is possible to engage the individual in some form of serviceable manual labor. The education of the feebleminded is usually a combination of instruction in elementary school subjects, such as reading, writing, simple arithmetic, etc., and training in industry, chiefly in those fields involving manual work. The instruction is gradually made more difficult until the defective proves himself incapable of comprehending more advanced subjects.

The highest grade individuals found in the schools for the feebleminded are often able to acquire considerable practical knowledge and in many cases render valuable service to the institutions themselves. An instance was brought to my attention of a feebleminded boy who came to an institution after an existence of neglect and privation, and who, after systematic training along the lines for which he was best fitted, namely, music and manual work, was later enabled to take charge of certain classes and eventually became the orchestra leader and a reliable attendant in the institution.[2] Another interesting illustration is that of a defective boy who showed such proficiency in manual work that he was placed in charge of the manual room and later was released as an inmate and placed on the pay-roll.[3]

It is a well-established fact that the best occupation for the feebleminded is farm work, the most important reason for this being that many occupations upon the farm do not demand a high degree of intelligence. Other reasons are: that the environment does not offer the complexity of city conditions; that the men are happier and more contented under the changing routine of rural labor; and that fresh air and outdoor exercise are inducive to good health, which so many of this class lack. The majority of schools for the feebleminded are situated in the country and are devoting considerable attention to farming and gardening and to canning and preserving the products. The fact that the institutions are yearly acquiring more acreage and enlarging their agricultural departments suggests the possibility that the school for the feebleminded may eventually be largely a self-supporting agricultural station.

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[1] Fernald, Walter E. The Templeton Farm Colony for the Feebleminded. Reprint from the Survey, March 2, 1912.

[2] Sixty-third Annual Report of the Pennsylvania Training School for Feebleminded Children, p. 12. Elwyn, Delaware County, 1914–1915.

[3] Sixty-fifth Annual Report of the Syracuse State Institution for Feebleminded Children, p. 15. Albany, 1916.

Besides farming, there are, however, many occupations in which the institutional feebleminded can be trained, and in which they can be remarkably productive. Doctor Sherlock, of England, states in his book *The Feebleminded* that defective individuals "are willing workers, and, if their work is so arranged as not to impose too prolonged a strain on their attention, their industry leaves little to be desired. Many of them are open to the stimulus of emulation and many, too, take so great a pride in what they turn out that any evidence of its being appreciated supplies a strong inducement to continued efforts at improvement. Almost all forms of manual labor are available for the feebleminded. . . ."[4]

If we look through the industrial departments of schools for the feebleminded in this country, we find that several branches of manual labor are being taught with marked success. It is customary for the different institutions to arrange exhibits of the output of the inmates, where a variety of well-finished handiwork testifies to the proficiency of the pupils. Among the industries practiced in these institutions, in addition to farming and gardening, may be mentioned carpentry, basketry, chair-caning, weaving rugs, hammocks, and towels, making rag carpets, shoes, mattresses, wells, chopping wood, painting, plumbing, printing, knitting, sewing, embroidering, tailoring, laundry work, general housework, and cooking. In some institutions, manicuring is also taught, with the aim of discouraging a prevalent practice among inmates of biting their nails.

At the beginning of industrial training, the girls and boys are usually instructed practically along the same lines, but later a differentiation of occupation is made. As far as possible, individuals are placed at trades in accord with their natural aptitudes.

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[4] Sherlock, E. B. The Feebleminded. London, Macmillan & Co., 1911.

At this point an idea suggests itself in connection with the expediency of vocational guidance among feebleminded individuals, based on a study of their mental constitutions. I believe that it may be possible to bring about better industrial adjustment of the feebleminded in institutions if, by the introduction of laboratory methods, we can detect in each individual the inherent characteristics that fit him more for one occupation than for another. Just as we find that not all normal individuals can be adapted to the same conditions, so we discover it to be the case with the feebleminded, for the defective individual differs from the normal mainly in being mentally under-developed. With the normal person, we can measure his amount of intelligence, we can determine the nature of his emotions, and we can discover the psychophysical characteristics which would make him most efficient in a particular type of occupation. The feebleminded subject presents to the vocational psychologist similar material for study. Laboratory methods should determine why a defective boy can do highly satisfactory work—say, in carpentry—while another defective boy who has received similar training and experience is a complete failure in the carpenter shop.

The factors responsible for any individual's occupation are various, chief among them being environment, education, and innate ability. When we deal with institutional cases, we find that the value of previous environment and education is, for the majority, greatly minimized and we have to confine our attention almost entirely to the question of such innate ability as there may be. Some feebleminded subjects, especially of the high-grade type, possess a certain degree of mechanical skill and usually can be trained to perform efficient work in mechanical trades; they may not, however, be able to concentrate long enough to attend continuously to detailed and monotonous work, and therefore the tasks assigned to them must be of short duration. It is of practical importance to place the inmates at tasks on the basis of their individual abilities. This can be done to greater advantage by examining each subject and detecting the intellectual and affective processes that have attained greatest development. If we know the demands of an occupation and the capabilities of an individual, we are in a position to declare whether he is fitted for the work or not. This statement applies equally well to the normal person and to the feebleminded case in an institution.

The nature of institutions makes it possible to place the feebleminded subjects in a favorable environment and, with proper supervision, to bring about a satisfactory industrial adjustment. However, when the same subjects are left to themselves, they are practically incapable of earning a livelihood. Some institutions report that from twenty to thirty per cent of the pupils discharged are self-supporting, but, as a rule, the percentage is not higher than ten to fifteen. No matter how much time we spend in training a mentally defective individual, we cannot create in his mind whatever ability is lacking through faulty development; we may be able to establish motor and sensory habits that will perhaps be of assistance to him in securing a living, but we cannot produce judgment nor planning ability. A self-supporting feebleminded subject may be able to earn sufficient money to cover his daily expenses, but he is almost never able to save anything or to regulate his economic activities.

While, as we have just said, some institutions claim that a fairly high percentage of the inmates they discharge become later self-supporting, other institutions furnish us with data showing that the majority of their discharges have met with industrial failure. In this connection, I wish to refer to some facts regarding the discharge of feebleminded patients which I have taken from the *Sixty-fourth Annual Report of the Syracuse State Institution for Feebleminded Children,* issued in 1914. Until that year the institution had no authority to retain individuals, for which reason it was forced to turn back into the community any inmates for whom there was a request. From October, 1907, to December 31, 1913, the total number of discharges from this institution was 359. Of these individuals, there were 319 of working age, that is, over the age of sixteen. Only eight of these cases were able to support themselves satisfactorily after leaving the institution; this number includes seven boys and one girl. There were eighteen who were partially self-supporting; of these, seventeen were boys and one a girl. By "partially self-supporting" is meant the ability to contribute something toward daily maintenance, but obliged to receive financial assistance before covering all expenses. The occupations followed by the 26 wage-earning individuals with the number of instances of each were:

Choreman	13
Shophand	6
Laborer	2
Errand boy	1
Farm hand	1
Salesman	1
U. S. Army	1
Unknown	1
Total	26

The maximum salary obtained by any of these individuals was $10 a week, while 12 of the choremen received nothing but board. Of the 359 discharges, 323 were unable to earn wages and continued to be cases of dependency after their discharge from the institution.[5]

We have so far dealt with cases placed in schools for the feebleminded. Let us next consider a somewhat higher type of mental defective found in institutions of a different nature, individuals not always presenting the characteristics of the clinical type, but nevertheless possessing a marked degree of mental deficiency, combined with active anti-social traits. In this class belong adults of both sexes who, by reason of their inferior mentality, fall victims to the influence of injurious factors and finally indulge in criminal behavior, thereby becoming a danger to the community and a burden to the state. I refer here to the defective individuals who constitute such a large percentage of our prison population.

These individuals, besides possessing subnormal development of intellectual functions, usually exhibit abnormal temperamental conditions. They are, as a rule, highly suggestible, lack ability to control desires, show little or no sense of responsibility, have little foresight, are deficient in perseverance, and easily become irritable. Psychological examination of these subjects generally reveals defective judgment and comprehension, poor memory, unstable attention, faulty apperception, and limited learning ability.

The number of defectives in prisons and reformatories has been shown to vary from twenty to forty per cent. In the Massachusetts

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[5] Sixty-fourth Annual Report of the Syracuse State Institution for Feebleminded Children, p. 23. Albany, 1915.

State Prison, it was found that the percentage was twenty-two,[6] while in Sing Sing Prison it is about thirty.

When we consider the industrial phase of this defective prison population, we are impressed by the fact that nearly all these individuals have engaged at some time or other in economic activity and that most of them have had a career of industrial inefficiency. Some of the most striking personal characteristics that we discover when we inquire into the industrial record of these subjects are their lack of habit of industry, their inability to retain a position for a prolonged period, their failure to persist in a specific line of work, and their want of ambition.

In an investigation of the industrial careers of fifty mental defectives now confined in state institutions in Massachusetts and New York, I found that the average age was twenty-nine years, and that very few had held less than five positions. The average mental age for this group was ten years. One of these cases was nineteen years old and had held sixteen positions. The statement becomes easily plausible when we realize that positions are often held no longer than two or three weeks.

The four cases following are presented as illustrative of the degree of success or non-success met by feebleminded subjects in economic life. As far as possible, no facts have been included here beyond those relating to the industrial careers.

The first case is that of a colored man, forty-one years of age, who is at present confined in a state institution. His father was a sea-faring man, and the subject worked with him as an assistant on the boat until he was twelve years old, when his father died. Following the death of his parent, he received employment on a farm, where he was paid a salary of $10 a month in the winter, and $40 a month in the summer. At the age of eighteen he left the farm and for a year held several positions as driver, doing miscellaneous job work at an average salary of $20 a month. When nineteen years of age, he married a normal woman, and, during the next few years, held eight positions as laborer, the longest time given to any one of them being six months. On account of his inability to secure a permanent position and also because of his desire to become a sailor, his father-in-law helped him to buy a small boat. Upon the acquisition of this boat, he went into business for himself. In the summer-time he took people on fishing expeditions; in the winter-time he secured money by renting his boat at $5 a day, or by dredging for oysters and clams. He succeeded in this line of work, making as much as $100 a day in the summer-time, but frankly admits that his success was due to his wife, who very efficiently conducted the business for him. Subject was arrested once for stealing a horse and was sentenced to a state reformatory. He was later arrested for receiving stolen goods and served a year in a penitentiary. He is now serving a third term for using his boat for immoral purposes. Psychological examination of the subject shows that he has a mentality of eleven years. This individual presents an illustration of the fact that a feebleminded person can do efficient work under proper supervision. He was fortunate enough to marry a normal, intelligent woman, who was able to conduct his business for him.

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[6] Rossy, C. S. Report on the First Three Hundred Cases Examined at the Massachusetts State Prison, p. 14. Bulletin No. 17 of the Massachusetts State Board of Insanity, January, 1916.

The next case is that of a young man, twenty-one years of age, of Irish descent. He began his industrial career at the age of fifteen, working on the delivery wagon of a laundry at a salary of $4 a week, but, a week after employment, decided to change his occupation and took a position on the delivery wagon of a grocery store. He began in this position with a salary of $6 a week and was earning $10 a week when he was discharged a year later on account of getting into an argument with one of the customers of the store. He then obtained work as assistant mechanic with a metal perforating company at a salary of $8 a week. After holding this position for a year and a half, he left the company, believing that he could do better somewhere else. He applied for work with a drying and cleaning company and was given a position at $10 a week, but was discharged three months later on account of an argument with his employer. He was now eighteen years of age. His next position was as clerk in a poultry market, where he was paid $12 a week, but, six months afterwards, he engaged in a fight with another clerk in the store and had to give up his position. He was next employed in a laundry as a wringer. Here he was paid $14 a week, the largest salary he ever received. He held this position two and a half years, until he was arrested on a charge of burglary and sent to prison. Psychological examination shows that this subject has a mentality of ten years. He is representative of the impulsive, irritable, temperamental, low-grade moron, and his failure in economic life is largely due to his emotional instability.

The third case is that of a colored man, eighteen years old, who has not retained any position more than one month. He is obedient, passive, and careful, but lacks perseverance, is slow, and becomes easily dissatisfied. The following is an account of his industrial career:

At the age of fourteen he was employed as switchboard operator in an apartment house, but kept his position only three weeks. He then served as hall-boy with a salary of $7 a week, but was discharged one month afterward because of his inefficiency. After being idle for a few weeks he secured another position as switchboard operator, holding this for one month; upon his discharge he was employed as automobile washer in a garage at $10 a week, but, after four weeks, became dissatisfied with the work and left of his own accord, later obtaining a position in a bowling alley. He was able to hold this position for three weeks. Having difficulty in securing any other kind of work, he again accepted employment as switchboard operator, but was discharged a week later. Then he became night operator in an apartment house at $7 a week, but remained in this place only two weeks. His last position was that of hall-boy, but, as before, he was not able to retain it for longer than a month. In the majority of cases, he was discharged on account of inefficient work; in a few instances, he left his position voluntarily, finding some cause of dissatisfaction. His maximum pay was $10.50 a week, while the average was $7. Psychological examination reveals that this subject has a mentality of eleven years.

The fourth case is that of a young man twenty-two years of age who shows a changeable disposition similar to that of the previous case, but who differs in the respect of being quick and active in his work. He is unable, however, to retain interest in any position and is fond of novelty. He began his industrial career at the age of eleven, when, as he says, his "father kicked him out of the house." He has held the following positions:

1. On a farm, for six years; salary $1.50 a day; left because he got tired of the work.
2. As driver; salary $1.50 a day, tenure, three months.
3. As driver for a truckman; salary, $1.75 a day; tenure, two months; left because he had a quarrel with another employee. Unemployed one month, then secured work—
4. As driver, salary, $1.50 a day; tenure, two months; left because work was not congenial.

5. As substitute, shoveling coal on a wagon; salary, $1.50 a day; tenure, one month.

6. As driver with circus; salary, $35 a month, with all expenses. After the season was over, kept going "on the road" with—

7. Other shows for two years. Then returned to his home city at the age of eighteen and was employed three months; was then arrested and sent to penitentiary.

8. As janitor in penitentiary; tenure, six months.

9. As helper on an express wagon; salary, 75¢ to $1.50 a day; tenure, three months; left because he got tired of the work.

10. As coal heaver in a coal yard; salary, $10 a week; tenure, two weeks; left because he had a fight with a fellow workman; unemployed one month, then secured position again—

11. As helper on express wagon, same salary as when previously employed there; tenure, four months.

12. As driver for the street department of his home city; salary, $1.50 a day; tenure, eight months; unemployed three months, then worked again—

13. As helper on express wagon; same salary as previously; tenure, two months.

14. As caretaker of two horses and two lunch wagons; salary, $9 a week with board and room; tenure, one month; left on account of alcoholism. Went to a western city where he stayed one month, unemployed, then returned to his home locality, where he worked—

15. As a farm hand for three weeks; salary, $1.50 a day; left because he did not like the work.

16. As driver for the United States Army; salary, $1.25 a day and board. Claims to have deserted the army.

17. Again as helper on an express wagon; salary, $1.50 a day; tenure, two months; discharged because he broke two trunks.

18. As coal heaver for the man with whom he had worked previously; salary, $11 a week; tenure, four weeks; laid off; came to New York City for a week, then returned to his home city.

19. As driver; salary, $12 a week; tenure, three weeks.

20. As helper on an express wagon; tenure, one month; was then arrested.

The mental age of this individual was found to be seven years. It is interesting to note that the family history reveals that a brother and a sister of the subject are in reformatories, that another brother is considered "foolish" by his relatives, that a sister is crippled and the mother an invalid, and that the father is alcoholic.

These histories are representative of the industrial careers of the feebleminded individuals found in penal institutions. As stated before, there is probably 30 per cent of definitely defective cases in a prison such as Sing Sing, and an approximately equal percentage is found in almost every other prison. Moreover, there are in such institutions many psychopathic individuals and a large number of alcoholics who have deteriorated to such a degree as to be unable to engage successfully in any but the simplest forms of labor. In view of the fact that such a large proportion of the prison population is composed of subnormal individuals, especially of high-grade defectives, the question of prison industry acquires importance and deserves a place in this discussion.

A considerable number of individuals sentenced to state prisons have never learned a trade nor have they had a steady occupation. The Psychiatric Clinic at Sing Sing Prison made a survey of a thousand inmates of the institution and found that the most common age at the time of commitment was twenty-four. In view of this fact we can safely say that many of these individuals who have not succeeded in economic life are, when committed to a penal institution, still at an age at which they could profit by training and perhaps develop a habit of industry.

Of course, the selection of a trade for an individual who has been an industrial failure is not an easy matter. Careful investigation and systematic experimentation is necessary. The Psychiatric Clinic, under the direction of Dr. Bernard Glueck, has recently undertaken the task of placing a man in the industry most suitable for him. This task is not hard when low-grade types of feeblemindedness are concerned, for, naturally, these subjects cannot be trained in difficult trades, although they can accomplish satisfactory results if placed under adequate supervision and assigned to simple labor. Similarly, the intelligent individual who has a trade and who has worked at it successfully presents a comparatively simple problem. However, when we have to deal with the psychopathic case or the high-grade defective, the task becomes at once complex.

The Psychiatric Clinic is attempting to handle the problem in the following manner: After each new inmate has been submitted to a careful medical and neurological examination, and has been questioned concerning his family and personal history, a special examination is then given to determine his aptitudes, and an investigation, as comprehensive as possible, is made into his industrial career. Data are accumulated relating to the number and types of positions the subject has held, salaries received, tenure of each position, reason for leaving, periods and causes of unemployment, interest felt in work, nature of position in which best work was done, and personal relations with fellow-workmen. The special examination to which I have referred is conducted with the aid of psychological methods; its object is to determine the degree of development of certain mental characteristics that are involved in industrial pursuits. We have arranged a tentative list including most of the mental functions required for different occupations, as for instance, constructive ability, planning ability, analytical ability, motor co-ordination, attention, etc. By the application of psychological methods, we are enabled to estimate roughly a subject's fitness for a particular line of work. Having thus analyzed the individual, we attempt to place him in the prison shops at the occupation in which he will be able to accomplish the most. An adjustment of prison labor in this fashion should bring to the prison a reduction of waste and, eventually, an increase in production and to the individual, familiarity with a trade which he could pursue after his discharge. It is easily understood why this undertaking is best accomplished by a Psychiatric Clinic when I explain that the majority of the inmates of the prison present a definite mental or medical problem.

We come next in our discussion to a consideration of the feebleminded individuals who are at large in the community. The majority of these defectives belong to the high-grade class, and their deficiency remains unrecognized until continued inefficiency or anti-social conduct demands attention. It should be understood that the term "feeblemindedness" does not necessarily involve complete dependency and absolute lack of ability to assume industrial activity. In the strictest sense, these high-grade subjects may not all fall within the category of feeblemindedness, for they may not show the biological characteristics of the type found in institutions; however, they lack the mental ability to adjust themselves to industrial life and make a success of it. When they are carefully examined, their histories investigated, and their intellectual qualities tested, they are found to be, after all, similar in many ways to the well-known institutional case. If these individuals do not come exactly under the biological classification of feeblemindedness, their inferior mentality and economic failure surely include them under the psychological and sociological classification; that is, they are feebleminded because their mental make-up is far inferior to that of the average individual and they have proven themselves unable to earn a steady livelihood or to save any money for future use.

The high-grade moron is the most capable of the mental defectives of actually earning a livelihood, and we discover him in almost every group of applicants for employment in positions which do not involve special ability. The employment departments connected with industrial concerns are not always prepared to detect him, and one is certain of finding employment assigned to any number of morons. As a rule, they are industrially inefficient, except in the very rare instances where proper supervision is provided and the occupation is of such simple nature that it does not overtax their limited ability.

For the purpose of determining the nature of occupations in which mentally defective individuals engage, we have selected for study 150 adult males diagnosed as feebleminded, who have been confined in state institutions. In investigating as far as possible the industrial careers of these subjects, we learned the following facts: 37 had been common laborers; 22 had done house and hotel work, acting as butlers, waiters, cooks, etc.; 20 had worked as chauffeurs, drivers, and teamsters; seven had been farmers; 22 had worked as shop hands; five as rag pickers and peddlers; seven as tailors and pressers, and 30 had engaged in mechanical trades.

The mental ages of the 150 selected subjects were as follows: three possessed a mentality of seven years; fourteen a mentality of eight years; 29 a mentality of nine years; 22 a mentality of ten years; 69 a mentality of eleven years, and thirteen a mentality of twelve years.

In correlating the mental ages of these individuals with the types of occupations in which they had engaged, we find that the subjects possessing the highest development of intellectual ability had been engaged in the occupations of chauffeur, clothing-cutter, electrician, attendant in hospitals, and painter. Most of those having a low-grade intelligence had been working as shop hands, farm laborers, laundrymen, and peddlers. Of the peddlers, not one had a mentality over ten years. For the group of common laborers and for the group of factory hands, the average mentality in each case was ten years. A fairly high mentality was found among men with trades such as shoemaking, carpentry, and bricklaying.

If we use these statistical data as a basis for a conjecture, we can say that, of the adult mental defectives engaged in economic activities, fifteen per cent are found doing factory work. In almost every manufacturing concern, we meet cases of intellectual defect, and these are, as a rule, the most costly employees to the factory. They are unsystematic in their methods of work, neglectful, and forgetful of their duties; they show little sense of responsibility, are noted for their lack of punctuality, and evince a readiness to leave their tasks at the slightest dissatisfaction, irrespective of consequences. There is a very interesting tendency inherent in these individuals to save money until a little has been accumulated and then to give up work with the idea that they can start a business of their own.

On account of this instability to which I have just referred, the intellectually defective employee causes his employer an increase in the natural turn-over of labor and likewise an increase in the expense of maintenance. It has been estimated that the loss that a company incurs when an employee is discharged or leaves voluntarily after having been employed but a short time is about $30. This is, in fact, a conservative estimate, for a great number of industrial concerns place the figure at $50.

To give an idea of what the labor turn-over means to a company, I wish to quote here the result of an investigation which I undertook in one of the manufacturing plants of this city. The conditions in the factory were such that the number of employees discharged monthly was greater than the number of employees actually necessary for carrying on the work of the factory; in other words, to fill one position, often two or more workers had to be engaged and were subsequently discharged in the course of one month. It was found that the factory had for the past year a turn-over of 108 per cent, while computations showed that the normal turn-over for that particular industry should not have exceeded 30 per cent. The company had, therefore, an excess turn-over of 78 per cent, which brought a yearly loss of approximately $48,000. It would be absurd, of course, to infer that this loss was due wholly to the employment of feebleminded individuals, but it can be safely stated that, if provision had been made by the company in question to eliminate intellectually inferior workers, the yearly loss would have been greatly reduced.

Employers have not yet realized the great advantage to be derived from the application of intelligence tests as an aid in distinguishing the intellectually inferior from the normal applicant for employment. In the few places where psychological methods have been introduced, results of practical value are being obtained. Among the institutions utilizing psychological methods for the selection of employees may be mentioned the Psychopathic Hospital of Boston.[7] During the past two years this hospital has followed the practice of submitting every candidate for employment as clerk or attendant to a systematic examination. As the results obtained at this institution show that the percentage of intellectually sub-normal individuals among candidates for employment as ward helpers is high, I wish to present here data relating to the examination of sixty consecutive applicants.

The examination consisted principally of the Yerkes-Bridges Point Scale, supplemented by as many special tests as in the opinion of the examiner were necessary.

The classification of the sixty candidates was as follows:

Intellectually inferior	12
Slightly sub-normal	10
Normal	38

All the subjects in the "intellectually inferior" group graded below 76 per cent according to the Point Scale, and their reactions were indicative of intelligence defect. According to the norms of the Point Scale, the mentality of these subjects had not developed beyond the intelligence of a child twelve years of age, or younger. Employment was refused to all of this group.

In the group of "slightly sub-normal" individuals are included those applicants who obtained a grading between 76 per cent and 82 per cent, that is, those who possessed an intelligence of from twelve to fifteen years; in the normal group are included all applicants who obtained a score above 82 per cent, that is, those who graded above the standard for the mentality of fifteen years.

It was interesting to note in connection with this study that a history of alcoholism, immorality, or delinquency was obtained from most of the cases of the intellectually inferior group.

It is an acknowledged fact that defective individuals occupied in steady work are less likely to engage in anti-social behavior. Unfortunately, a large number of them fail completely in their industrial pursuits and gradually drift into a life of alcoholic indulgence, delinquency, and immorality, especially if they fall under the influence of an undesirable environment. It is believed that a large percentage of feebleminded girls become prostitutes. In an investigation made at the instigation of the Massachusetts Legislature, it was discovered that as many as 51 per cent of the prostitutes confined in the prisons, houses of detention and industrial schools in the State of Massachusetts were definitely feebleminded.[8]

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[7] **Rossy, C. S. The Yerkes-Bridges Point Scale as Applied to Candidates for Employment at the Psychopathic Hospital. Boston Medical and Surgical Journal, Vol. 175, p. 822–824, December 7, 1916.**

Many vagrants are mentally defective. Doctor Terman, of Stanford University, in his recent book, *The Measurement of Intelligence*, says, with regard to an investigation conducted among tramps:

"Of 150 'hoboes' tested under the direction of the writer, at least 20 per cent belonged to the moron grade of mental deficiency, and almost as many more were border-line cases. To be sure, a large proportion were found perfectly normal and a few even decidedly superior in mental ability, but the ratio of mental deficiency was about fifteen times as high as that holding for the general population. Several had as low as nine or ten years' intelligence, and one had a mental level of seven years. The industrial histories of such subjects, as given by themselves, were always about what the mental level would lead us to expect—unskilled work, lack of interest in accomplishment, frequent discharge from jobs, discouragement, and finally the 'road.'"[9]

Professor Eleanor Rowland, of Reed College, and Glenn R. Johnson, now of Columbia University, have found a similar percentage of feebleminded subjects in an examination made of 108 unemployed charity cases in Portland, Oregon.[10]

The possible relationship between mental defectiveness and accidents in factories is worth investigation. The prevention of accidents is one of the most vital problems in the field of industry. Statistics show that 2,000,000 men and women are injured each year in the different industries of the country. This means that one person is injured every sixteen seconds. In New York State alone, 683 accidents are reported daily to the Workmen's Compensation Bureau,—in other words, an accident every two minutes.[11]

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[8] Report of the Commission for the Investigation of the White Slave Traffic, So-called. Commonwealth of Massachusetts, House—No. 2281, p. 28. February, 1914.

[9] Terman, Lewis M. The Measurement of Intelligence, p. 18. New York, N. Y., 1916.

[10] Johnson, Glenn R. Unemployment and Feeblemindedness. Journal of Delinquency, vol. 2, p. 59–63, March, 1917.

[11] Wilson, Lewis A. Safety First for Vocational Schools, p. 7–8. University of the State of New York Bulletin No. 621. August 15, 1916.

Factories have devoted much time and money to prevent accidents, and numerous books and pamphlets have been written on the subject but, with very few exceptions, the direction of improvement has been towards developing safety devices rather than towards studying and adjusting the individual worker. Possibly the reason for this may be the fact that the average employer assumes that every employee is a normal individual. A great number of the workmen engaged in factory labor are, however, incapable of displaying normal judgment and reasoning power. An individual who strikes a match in a room filled with inflammable vapor, or who leaves a box on the floor of a dark passage-way, or who places a ladder directly in front of a closed door before mounting it, is certainly below the normal in sense of responsibility and power of analysis.

In the first issue of *The Spirit of Caution*, published by the Conference Board on Safety and Sanitation, examples are quoted of the explanations of accidents given by a group of metal workers applying at the Dispensary for medical treatment.[12] Among others, we find statements like these:—"My necktie caught in the drill spindle." "I tried the snap gage while the lathe was still running." "His truck came along and knocked my ladder from under me." "I stumbled over a belt shifter lying on the floor." All these explanations show that the accidents occurred through carelessness or negligence.

Knowing that there is a large percentage of intellectually defective individuals employed in factory work and sometimes assigned to dangerous occupations, we cannot help feeling that intellectual inferiority is in a great measure responsible for the many accidents in connection with industry. I recall the case of a young girl who lost three fingers of her right hand while working on a corrugating machine. Physically, this girl was able to run the machine; mentally, however, her development was equal to that of a twelve-year-old child. I am sure that no employer would have considered putting a child of twelve years in charge of that dangerous machine.[13]

There is a question that has, perhaps, occurred to many minds, How can the factory determine the mental status and competency of its employees? In attempting to answer this question, I desire, first, to describe the method of procedure commonly followed by most factories when a new man is employed, and, second, to indicate wherein these conditions could be altered and improved.

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[12] Bonehead Acts of Workmen. The Engineering Magazine, p. 442. June, 1916.

[13] The employment in a large powder factory of a patient who had escaped from a neighboring school for the feebleminded was recently mentioned in the daily press.

In most industrial concerns a centralized employment department is, as a rule, the agency for selection, adjustment, and supervision of workers. Whenever a new employee is sought, the foreman of the department concerned sends a requisition to the employment office, which then advertises for the worker desired, or selects him from the crowd that is constantly pouring into the office, or finds him on the waiting list of men who have previously applied for employment. The candidate is asked to fill out an application blank, and his references are investigated; after a few minutes' conversation with the employment manager, he is appointed or sent to the foreman. The selection is almost always made in a superficial manner. The man is "tried out" at the occupation and, if he is not efficient, is discharged, and a new requisition is sent to the employment office for a second man to fill that position. The loss of time and energy involved in such a procedure is accompanied, as has been already pointed out, by a considerable expense to the company.

A more satisfactory system of selecting employees could be secured by altering the method of inquiry at present used in employment departments and by introducing psychological tests and physical examinations. The preliminary inquiry should include a comprehensive investigation into the life history of the candidate, into his mode of living and habits, his education, and his medical history. Furthermore, a detailed account should be obtained of his economic activities, with special reference to the type and number of positions held, wages received, and periods of unemployment. Psychological tests should be applied to every candidate for employment with the object of determining the nature of his general intelligence and any special abilities that he may have. If the preliminary investigation of the candidate's history and the results of the psychological examination are satisfactory, the next step in the procedure of the employment office should be a physical examination into the condition of health of the subject.

A system such as outlined would doubtless involve in the beginning considerable expense to the company but would prove profitable in the end through the increase in production and decrease in the turn-over of labor.

Employers are beginning to realize that maximum prosperity for a company can best be obtained by securing maximum prosperity for the employee. The establishment of a special bureau in connection with manufacturing concerns, for the purpose of studying the individual worker, developing his capabilities, and adjusting him to his task, would be, perhaps, the most satisfactory means of meeting the majority of the employment problems of modern industry.

Such bureau would have for its chief function the increasing of the mental efficiency of the employees. Its duties would cover, in addition to the selection and adjustment of workers, matters relating to medical attendance, improvement of working conditions, sanitation and hygiene, prevention of accidents, regulation of wages, and betterment of living conditions. The psychopathic worker, the alcoholic case, the mentally diseased subject whose insanity is not yet evident but who is gradually deteriorating, the neuropathic individual, and the mental defective, all of whom are often found in factory work, would fall under the supervision of this bureau. In short, the bureau would deal directly with all employees needing its assistance.

Among the most important points that have been developed in this discussion are:

1. That feebleminded individuals, with the exception of the lowest type, are trainable.

2. That a feebleminded person can do efficient work if properly supervised and placed at an occupation for which he is fitted.

3. That there is a considerable percentage of feebleminded individuals independently engaged in economic activities and that, on account of their emotional instability and tendency to change positions frequently, they are a great expense to their employers and a hindrance to the highest possible output.

4. That intellectual inferiority is responsible for many accidents in factories.

5. That, by means of psychological tests and scientific methods of selection, undesirable workers can be eliminated from the mass of those seeking employment and better industrial adjustment can be provided for defective individuals.

6. That the establishment of special bureau, such as a Mental Hygiene Bureau, in industrial concerns would ameliorate the condition of workers and eventually raise the standards of industry.

THE PRACTICAL FUNCTION OF THE PSYCHIATRIC CLINIC*

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THE chief object of this paper is the discussion of the relation of social service to psychiatry. When a patient has been committed to an institute, that institute is responsible for his welfare so long as he is within its walls. When released on parole there is no longer direct contact between the patient and his physician except on occasional visits, and the general oversight of the case must be left to a greater or less extent to the after-care agent. This aspect of social service work has been recognized and its value well appreciated for a number of years. There is, however, another branch of this work which is much less known, and is probably of vastly greater importance. I refer to the care of the mentally abnormal whose disease has not progressed to the point demanding commitment. This work is essentially prophylactic, and should, therefore, if only from an economic standpoint, demand the attention of the State Hospitals, because every patient kept out of an institution for a month represents just that much lightening of the hospital load. This prophylaxis, moreover, is of the greatest psychiatric and human interest, and it is in this field that social service work is of unique importance. Much could be said in general on this phase of the work, but I have thought it probably more useful to focus my remarks on actual observations; to give you an idea of just what may be accomplished, and of the rôle of the social service worker in these achievements. For this purpose I have made an analysis of one hundred consecutive cases seen by myself at the Cornell University Medical School, in the dispensary operated jointly by the Psychopathological Department of the University and by the Mental Hygiene Committee of the State Charities Aid Association.

Other cases in the dispensary may have been more brilliant in their results, but it seemed fairer to present only those that I myself have seen, as the same criteria for judging the success or failure can be applied to all of them.

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*Read at a conference of the New York State Hospital Commission with the State Hospital Superintendents, held at Manhattan State Hospital, Dec. 12, 1916.

The therapeutic results in any dispensary are likely to be far behind those of private practice. This is particularly true in psychiatric work, and it must therefore be borne in mind that the incomplete success or actual failure of the dispensary is not an indication of what the trained psychiatrist can do in the treatment of neuroses and psychoses, but is much more a measure of the insurmountable difficulties to be met with in charitable work. In fact, when one considers the physical disabilities under which the clinic at Cornell labors, it is surprising that good results are ever obtained. And in order that you may keep this in mind when hearing the results of our work, it may be well to mention what these are.

The clinic is held in a class room about thirty feet by thirty-five or forty feet in size. In one corner is the desk of the social service worker, and the file of histories. In the middle of the room sit the patients who are waiting for examination. At the other side of the room from the social service worker is the examiner's table, separated from the rest of the room merely by a flimsy cotton screen. It will be immediately understood that under these circumstances no complete physical examination can be made when such is required, and that a discussion of the intimate affairs of the patient can never be carried on with any real privacy, since everyone in the room can hear all that is said, unless both patient and physician speak in a voice little above a whisper. Another difficulty lies in the fact that the clinic is undermanned, and the physician is frequently forced to give a patient only fifteen or twenty minutes of time when one or two hours would be little enough to devote to the problem in hand. It must be remembered, too, that, more than in any other branch of medical work, we are dealing with those who are burdened with bad heredity and environmental difficulties which are beyond remedy with the present organization of society. As you all know, a great deal of mental abnormality is engendered or fostered by unhappy human associations, and it is not easy to take the patient away from the influence of an unsympathetic family or employer, particularly when, as is usually the case, the patient is economically dependent on the maintenance of these relations. For these reasons it is therefore plain that what psychiatrists have learned in recent years of the psychological factors tending to develop abnormal mental states cannot be applied to best advantage in the clinic, and that one must be satisfied without a full psychological analysis of the patient's difficulties or the environmental changes which his judgment tells him are imperative.

On the other hand, we have been extraordinarily fortunate in the aid we have received from the Mental Hygiene Committee of the State Charities Aid Association, and we have always been able to count on the social service work's being carried out as completely as is physically possible. For this we have to thank the intelligence and sympathy of Miss Tucker and her successor, Miss Taft, but most of all are we indebted to Miss Wells, who has taken by far the largest share of the work connected directly with the clinic.

Our situation having been explained, I can proceed to outline the practical aims of the clinic. Naturally, we hope in every case to produce a cure, but this is a result which is most rarely obtained. In this connection it must of course be remembered that I am speaking of "cure" in a psychiatric sense. In many of the cases which I shall report with the result "improved," the patient himself, his family or friends would say that a cure had been effected, whereas the psychiatrist who can recognize the persistence of potential difficulties is more conservative in his claims. Practically speaking, therefore, our aim comes to be an alleviation rather than a cure. The patient who has not been working is brought to be self-supporting. The one who has been in active conflict with his environment is taught to adapt himself. Society is protected from the abnormality of the patient who has been a menace to it. In all these matters it is evident that the results are of social rather than individual value. In this connection it is important to emphasize one of the chief activities of the clinic in its advisory capacity to charity organizations. Of the one hundred cases to be reported, no less than forty-eight were referred by charitable organizations, and in practically all of these cases the association in question needed advice as to whether aid should be given to the patient, and if so, how that aid should be applied. The growing recognition of the value of the clinic to these organizations has been gratifying. The reasons why charitable societies are forced to turn to the psychiatrist for advice may be plainly understood when one remembers that trouble of any kind produces mental disturbances. These troubles may be essentially external or internal in origin, and it is only the psychiatrist who is able to differentiate between the symptoms produced mainly by environmental stress, and those for which inherent abnormality is mainly responsible. These two groups, therefore, which may be superficially alike, require quite different treatment at the hands of those who would give them help.

The methods of treatment adopted are chiefly these. When the patient has sufficient intelligence and insight to justify the attempt, a discussion of his difficulties from the psychological standpoint is essayed. It must be understood at the outset that one could not call this psychoanalysis as one speaks of that method in private practice. The analysis in the clinic is at best superficial. It is important, in understanding the practical function of the clinic, to note that in the one hundred cases, such analysis was attempted, even in the smallest way, with only ten or twelve of the patients. With a much larger number the psychotherapeutic measures could more properly be grouped under the heading "suggestion," using that term in its widest sense. The diagnosis, where possible, is explained to the patient, and he is encouraged to believe that he can take the situation in hand himself and that he should fight against the purely subjective symptoms. In patients whose difficulties have been for a long time fostered by a belief in some physical ailment, a candid discussion of the diagnosis is often of considerable value.

Not infrequently in an unstable individual, the factor which may make the difference between a tolerable and an intolerable existence is the presence or absence of some minor physical trouble. For this reason medical advice, particularly sound directions as to physical hygiene, is not infrequently of great value. Allied to this are measures which, though apparently physical, have a large indirect mental effect, such as the use of baths, exercises, and the timely use of sedatives or tonics. Most important of all are the environmental changes which are carried out through the agency of the social service workers. In these cases, some particular strain from which the patient suffers may be relieved and the mental balance resumed. A mother, whose household duties have become more arduous than her mental capacity will tolerate, may have her children taken care of for a few weeks. The wife whose domestic situation has become intolerable can be supported away from home for a short time. The adolescent who is chafing under the restraints of home can be given aid while establishing himself independently. In all such cases it must be borne in mind that we do not consider that the benefit derived is really physical, but that the strain of adaptation is temporarily too great for the patient, and that a brief relaxation of his efforts may make a better adaptation possible when he has gained a little surplus of mental energy. It must be remembered that such relief is never given when it seems likely that the patient is permanently incapable of adaptation, in which case charity becomes pauperization. It is in such situations that the psychiatrist is capable of giving expert help.

We can now proceed to a discussion of the different groups. The largest of these is that of the *psychoneuroses*. It is natural, as these represent the mildest type of mental abnormality, that improvement in their condition is most frequently secured. The statistics of this group may be of interest. There were twenty-four such cases, out of a total of one hundred. Of these, the etiology was thought to lie preponderantly in the make-up of thirteen cases, and of these thirteen, the condition of two remained unchanged; six were not heard from after the initial visit; five were improved, with two of these latter possibly cured. Of those where the etiology seemed to be preponderantly environmental, (that is, where the patient was subject to an abnormal strain) there were four, and of these, three were improved, and the result of one is not known. Both make-up and environment seemed to combine in the production of symptoms in seven cases, of which six improved under treatment, with the result of one not known. It is evident from these figures that the poorest results were obtained where the trouble lay primarily within the individual, so that external help (largely through the social service work) could be expected to be of least value. On the other hand, among the twenty-four psychoneuroses, it was thought advisable to attempt some psychological discussion of the symptoms in eight cases, and all of these showed some improvement, whereas one could be said definitely to be cured.

The different sub-groups may next be considered. There were four cases of *sexual neurasthenia.* As this trouble is nearly always precipitated by faulty preparation for sex development, and most frequently the result of false information, it is natural that a careful explanation of the real facts and a discussion of the origin of the symptoms would produce considerable relief. And it is this group which produces the most striking results. The patient who appears at the clinic depressed, with a history of inefficiency and a conviction of his mental and physical failure, will reappear a week after his only interview, cheerful and energetic for the first time in months or even in years. Unfortunately the brilliancy of this result is only temporary in many cases, since these troubles have entered rather deeply into the make-up of the individual, and require a long course of psychological treatment for eradication. Nevertheless, none of them seem ever to sink to the same depths as those in which they once floundered.

There were five cases of pure *anxiety neurosis*, and two of anxiety to which was added a hypochondriacal tendency. Of these seven, five were improved, one of whom was possibly cured; the results of two are not known. Three of these cases may be briefly cited.

J. S. applied to the Charity Organization Society, claiming to be deserted by her husband and in need of financial aid. She exaggerated certain physical troubles and had an obsession that her boy was incorrigible. She was talkative, had no application in her work, and thought that people did not appreciate and were against her. Examination revealed only symptoms of a bad anxiety neurosis, which had dated from the death of her mother and was aggravated by the absence of her husband. She was advised to take her physical symptoms less seriously, and directions were given to the society as to how her environmental difficulties should be smoothed out. The result is that husband and wife are now living together and that she is supporting her child and is reasonably content.

E. B. is a woman who had three children by her husband before marriage, this husband being utterly shiftless. She suffered from a uterine retroversion which could not be operated on because of an organic heart condition. She was reported to be subject to frequent excitements with bad temper, and was suspected of being intellectually inferior. This is obviously a case of great difficulty, where any improvement might be regarded as an achievement. The examination showed that she had no intellectual defect, but that she was worrying and brooding a good deal about real troubles, that she slept poorly and had bad dreams. It was recommended that her child be taken care of temporarily, and that she be given a rest in the country. This was done, and the child was placed in a day nursery while the mother worked. Since then she has been getting on fairly well and is apparently self-supporting.

L. S. is a woman in whom the menopause occurred three years before she came to the clinic. She complained of being "nervous" since that event, but her worries were found to go back to a sex experience sixteen years previously. She was given advice on her sex problem and hygienic measures were prescribed, including a short rest in the country. As a result, although she has not completely recovered, there has been a great improvement and she is working well.

There was one case of *phobias*, which did not return after the first visit.

There were six cases of *hysteria*. Of these, three improved, with the results in the other three not known. One case may be noted. She was a girl of fourteen when she first came to the dispensary and had been living with different foster parents for some years. These parents reported that she had attacks of sleep-walking and convulsions. Examination showed that she was suffering from the Froelich type of hypophysial obesity with constipation, irregularity of menstruation, and lethargy. In addition she was seclusive, suffered from many anxious dreams, and was obsessed by fears of tuberculosis. She was given extensive physical examinations in a hospital, diet and medicines were prescribed, and the environmental influences were carefully controlled. As a result there has been a considerable improvement in the physical symptoms, with a marked loss of weight, a recovery from her sleepy spells, the hysterical convulsions have not returned, her fears have disappeared and she is working rather satisfactorily, although still somewhat lethargic.

There were four cases of *compulsion neurosis*. Of these the condition of two remained unchanged, the result in one is not known, and only one improved. The history of this last patient may be briefly given.

The patient is an unmarried Swedish woman of thirty who obtained very high wages as a cook. Nine months before she sought treatment her father died. A month after his death the thought suddenly occurred to her, "I wish father were in Hell." This was repeated as a compulsive thought, with variations of torture inflicted on him; a compulsive cursing of God, the thought that she was cooking her father's flesh whenever she cut any meat, etc., etc. Tortured by these thoughts, she obtained practically no sleep for months, had frequent headaches, was able to eat very little, and naturally suffered considerable loss of weight. Her case was different from that of most compulsive neurotics, however, in that she never developed the idea that work was bad for her, and she stuck to her duties with admirable tenacity. This made the prognosis more favorable than in the ordinary dispensary case of compulsion neurosis. The treatment, which was carried on for a number of weeks, consisted of encouragement, the suggestion that the symptoms were temporary, and a superficial analysis of her difficulties. In two months there was a marked improvement, so that she slept and ate well, and became fairly free from her painful thoughts. She has not been heard from for over a year, which is probably an indication of continued improvement.

It may be remarked incidentally that with a neurotic patient a failure to return for further advice is very often indicative of relief from the symptoms, and that it is therefore safe to presume that our results are somewhat better in this group than the statistics would indicate.

There was one case of pure *hypochondria* with a dispensary habit, in which there was only a slight and doubtful improvement.

There was one case of *tic* which is interesting enough to be described. He was a bright shy child of eight, who had few amusements. At school he was bullied by the big boys, and probably was struck by his father at home. He developed a tic of pulling his mouth to the left, shaking his head and then turning it to the left. These symptoms developed after making these movements when shrinking away from the big boys who struck him, and they lasted several months without any improvement. It was explained to the patient that these movements were an indication of fear, and measures were taken to protect him from aggression both at school and at home. It was recognized that he probably would not have developed a neurosis if his life had not been so cramped, if he had enjoyed a few of the amusements normal for his age. He was asked what his chief ambition was, and finding that he wished for a pair of roller skates more than anything else in the world, the money was given to his parents to buy a pair. It is typical of the obstacles encountered in dispensary practice, that the chief difficulty in this case was to persuade the parents to use the money for this purpose, as they persisted a long time in the conviction that the child needed medicine and that his trouble would only become worse if he were allowed to play on the street. After some pressure was brought to bear on them, however, this treatment was instituted and a complete recovery resulted in a few weeks, when the boy returned and was able to boast of being able to beat "some of the big guys" in racing on the roller skates. The mechanism of recovery in this case is instructive. The antagonism to the big boys obtained a natural outlet instead of appearing as a symptom.

The next largest group was that of *dementia praecox*, of which there were twenty-one. Of these, commitment of four was advised at the time of the first examination. One was committed six months later. The subsequent history of nine is not known at present, but of these, a certain number will be brought back when the symptoms become worse, so that we may presume that they are fairly well. Four have shown improvement. The condition of four has remained unchanged, and in one case there is an apparent recovery. In this group of dementia praecox the situation which is attacked is almost always a social one. The facilities at the clinic are such that it is idle to hope for radical improvement in any but exceptional cases. The aim is, therefore, to get the patient to work, keep him at it as long as possible, and see that his psychosis does not seriously affect those in his environment. The last is a most important consideration, and we find time and again that the delusions of these patients result in grave maladjustments at home which tend to produce nervous and mental trouble in the other members of the family. The clinic does good service to the community in many cases by advising commitment at an earlier stage than would otherwise take place, thus confining the trouble to one individual. Two cases in this group may be cited.

L. J. was thirty-three when first brought to the clinic by her employer, who reported that she was irresponsible, unsatisfactory in her work, that she appeared silly and had no will power, and that her behavior was occasionally erotic, while she gave accounts of erotic experiences which were probably pure fantasy. In a brief examination no trends were elicited, but a diagnosis seemed justified on the basis of her apathetic attitude and inappropriate affect. Those who were responsible for her were warned to watch for the outbreak of more marked symptoms, and employment was secured for her with an indulgent family to whom the situation was fully explained. She worked well for two months, then had a period of erotic behavior which improved when she was scolded or discharged, after which she returned to work again, satisfactorily enough, for another period. It is likely that grave social complications would have arisen with this patient had she not been placed under this supervision. Her disease had not developed to the committable stage, and even if she had been committed the community would have lost that measure of productive activity of which she was capable. This case is quite typical of the methods and results of the clinic in handling these cases of dementia praecox.

The other case is cited, not because it is typical, but because it gives evidence of what may be accomplished by intensive efforts.

F. K. was eighteen years of age when she was brought to the dispensary. For two years there had been a progressive definite loss of interest, and an increasing seclusiveness, culminating in her abandonment of her high school work, remaining practically mute at home and eating little. The examination showed no depression, no obvious apathy, but a tendency to silly smiling. There was no scattering of thought, but there were grave inconsistencies in her account of symptoms, and she constantly gave the impression of withholding delusional thoughts. This case is possibly not one of dementia praecox, but the history and the symptoms, so far as they went, were more closely allied to this group than to any other, and it is my opinion that if treatment had not been instituted, pathognomonic symptoms would shortly have developed. It was recommended that she be removed from her home environment and forced to some steady occupation that would keep up her interest, and that her seclusive tendencies should be steadily combatted. Miss Taft undertook to follow out these directions, and spent in what seemed for a time to be a fruitless endeavor a great amount of valuable energy. She took the patient to work in her own office, and for some weeks she was a very difficult and trying helper, resisting all suggestions and replying to everything with "What does it matter?" or "What difference does anything make to me?" Miss Taft's patience was finally worn to the breaking point, which the girl saw, and this was apparently the first thing to make any impression on her. After quite an emotional upset, she expressed gratitude for what had been done, and contrition for the trouble which she had made. From that point onward, her improvement was marked. She is working quite satisfactorily, and has become a great favorite with all her associates. Superficially, at least, she is perfectly well.

There were seven cases belonging to the rough group of *manic depressive insanity*, varying from serious acute psychoses to a more or less chronic, incapacitating depression. It is not unnatural that all the cases were depressive, either pure depression or complicated by an anxiety state. In one, commitment was advised and carried out with excellent result. In two, there was no change. In two the results are not known, and in two there was improvement which could be traced directly to the treatment. It is rather interesting that in only two of these cases did environmental factors seem to be of sufficient importance to justify the co-operation of the social service department. In other words, in this group the make-up of the patient appears to be the more important factor, so that psychotherapeutic measures are indicated. With conditions such as they are, these measures cannot be expected to be very effective, which accounts for the fact that only two instances of improvement can be claimed from these seven cases.

An interesting group is that of the fourteen cases which are classed under the rough heading of *psychopathic constitution*. Of these, four were plainly cases of moral defect, two were alcoholic, three were psychopathic children. Of the others, one was a case of homosexuality; another of abnormal egotism combined with unusually strong sex impulses. Another cannot be better diagnosed than by saying that he was too proud to work and that he suffered from the conviction that the world owed him a living. One case was of psychotic instability where mild external difficulties would lead to definite psychotic episodes of a typical nature. Another had a cyclic make-up,'with abnormal enthusiams, sympathies and antipathies. Improvement can be claimed in only three of the fourteen cases, but that does not indicate that the clinic was of no use in the other eleven. The majority of these cases were applicants for relief, where the charity organizations were in a quandary as to whether relief should be given or not. The opinion of the physician as to the chronicity of the patient's difficulty is naturally of value to the charity workers. Two of these cases are of sufficient interest to justify special mention.

H. M. had been for a short time a patient at the Central Islip State Hospital where a diagnosis of constitutional psychopathic state had been made. Following parole she had worked fairly satisfactorily for two years, but for two weeks preceding her introduction to the clinic she had been confused, showed queer conduct, and had been in bed most of the time. It was found on examination that her upset was apparently due to discussions and worry about the war. It was thought that she would be benefitted by a brief relaxation from the strain of adapting herself to the environment, so she was sent to the country for a couple of weeks, where she made a very fair recovery, and returned to work, at which she continued for ten months. The next upset was due to sensitiveness to gossip, and to the inquisitiveness of her fellow employees, concerning which she developed a rather paranoid attitude. An investigation at the place of her employment showed that there was some basis for her complaints. Improvement again followed a brief rest in the country. In this case it is highly probable that if she had not had the clinic to turn to, her condition would have become worse and commitment would have resulted, with a long absence from work and the inevitable discouragement incidental to it.

K. H. came to the clinic at the age of twenty-three, complaining of vague nervousness. He was found to have a cyclic make-up, to be irresolute, with much violent feeling on social problems (his views bordered on anarchy) and extreme reactions to family situations. He never worked in any factory without fomenting a strike, and had been prevented from shooting his father during the course of a domestic quarrel only by the interposition of a friend. He was intellectually much above the average of his social level, with excellent command of English and strong literary tendencies, but had never been able to accomplish anything because of his emotional instability. On account of the patient's intelligence a considerable amount of time was spent on his case, and he reacted in an almost startling way to any analytic interpretation of his attitude. For instance, after it was explained to him how his antagonism to employers and to his father had arisen, he worked eighteen hours a day for six weeks for his uncle, and developed the business of the latter to an extraordinary degree. Similarly, when he told of a rather foolish love affair which was causing him a great deal of worry, an analytic interpretation led to his putting all thoughts of the girl completely from his mind. He still lacks objective in his activities, but in spite of this has gained considerably on the whole. If he had not come to the clinic, his energy would have gone entirely in the direction of fomenting social unrest, and the probable commission of actual crime.

There were six cases brought for examination as to *intellectual defect*. Three were sent to institutions, one was recommended to the ungraded class of a public school, and in three cases directions were given for physical and mental hygiene at home. The results in none of these cases are known, which is not unnatural, as all were brought merely for diagnosis.

An examination for intellectual defect in these days when set "psychological" tests are used to brand all kinds of failures with the diagnosis "feebleminded," is of particular value when made by one who is familiar with mental abnormality as well as subnormality.

One case may be cited to illustrate this. A child of seven years had been given the Binet-Simon test by her school teacher, and pronounced to be feebleminded, and was therefore to be placed in an institution for defectives. Examination at the clinic showed that the child had defective hearing and eyesight, was shy and sensitive, but there was no evidence of definite intellectual defect. Her home environment was altered, and she was not interned in an institution.

A most important group of nine cases is that which can best be spoken of under the rough heading "*social suggestions.*" These are cases where parents, school teachers, or social workers bring to the clinic problems in which it is thought that psychiatric opinion may be of value. There are in this group three cases where charity organizations were suspicious of there being some mental abnormality, although the need brought to their attention seemed to be genuine enough. One of these was a woman, probably paranoid, who was a chronic appealer for aid. The society was advised to give her no further assistance without definite evidence being offered by the patient of willingness to work. Another was a young man who was using his neurotic symptoms to excite sympathy. In another, the destitution of the family was found to be traceable to the paranoid condition in the father, and the society was so advised. There were two cases in which children were developing bad habits. The psychological factors in these cases were exposed, superficially at least, and the parents given advice as to education and discipline. In one there was improvement; in the other the result is not known.

Another very interesting situation was that presented by a woman of forty years, and her son. Following her experiences in confinement, the woman developed fears of anaesthetics. Eighteen months before coming to the clinic she had suffered a miscarriage, and at this time she was much disturbed by fears of operation. From then on she has had the idea that her second child was suffering from various ailments, that he would be taken from home against her will, be operated on and die, and that her husband would be killed. She thought that her dead parents wanted her to join them because she was always dreaming of them. She was antagonistic to the Charity Organization Society and suspicious of her neighbors. When examined, her affect was not fully appropriate. This case, possibly one of dementia praecox, was obviously that of a woman whom it would be very difficult to handle. The complication arose from her fears about the child. He was a boy of eight years who for eighteen months had been dragged around from one dispensary to another by his mother, who always insisted that he was suffering from various ailments. The boy himself complained of his symptoms only when they were directly suggested to him at the time of the examination, and the mother did not allow any examination to be conducted except in her presence. The boy was normal, apparently, in school, and when he had occasionally been away from his family in the country he was also quite well, but naturally he was absent from school much of the time, and was prevented by his solicitous mother from enjoying all the normal activities of boyhood. It was strongly advised that the boy and his mother be separated, but in this the mother steadily refused to acquiesce, and there was unfortunately no legal pretext for their separation. The boy's outlook is naturally very bad. This case is cited, not only for its intrinsic interest, but also because it is an exaggerated example of the type of influence which is often at work in homes where a solicitous parent is fostering a hypochondriacal attitude in a favorite child.

Another case of this group may be cited, showing the striking value of expert diagnosis. The patient is twenty-seven years of age, and has been a widow for seven years. A year and a half before her case was brought to the attention of the clinic, she was deceived by a man who made promises of marriage and robbed her of her savings. After fifteen months of this unhappy union he deserted her with a ten months' baby on her hands. In absolute destitution, she attempted suicide. After her arrest the case came into the hands of a charity society that wished to have her committed as an irresponsible or insane person. Others in the organization, not so convinced of her abnormality, had her brought to the clinic where a thorough examination revealed nothing to suggest either an abnormal make-up or a depression going beyond the limits of the natural reaction to her unhappy fate. The charity society was therefore advised to take care of the child and give the mother every necessary assistance. The results of this treatment are now apparent, and the mother is financially independent, supporting the child, and as happy as anyone in her condition could be.

Finally, there were some nineteen cases which we are forced to put into an *unclassified* group. Among these were five neurological cases referred to the neurological department in the Cornell dispensary and to different hospitals. There were three cases of paresis, which were sent to Bellevue Hospital. There were two cases of epileptic deterioration in which environmental treatment was advised. There were several medical cases with neurotic exaggerations of symptoms where suggestion and environmental treatment were given. There was one case of involutional depression, previously in Manhattan State Hospital, which was returned there; another of the same type, not before treated, was sent to Bellevue Hospital. There was one adolescent, without symptoms, who came for advice in sex matters; and finally, there was one case of a girl with delayed menstruation, abnormal tension and hysteroid "convulsions," whose condition was much improved by general hygienic measures.

As the one hundred cases have now been outlined, we can briefly summarize the work. It is seen that in the group of psychoneuroses there is improvement in, roughly, one half of the patients, which is probably to be considered as a favorable result when one takes into account the disabilities under which the work is done. In the remainder, or three fourths of the cases, the main function of the clinic is seen to be diagnostic and advisory. The value of this work can be judged by the fact that of the one hundred cases there were improvements in forty-four of the situations, either individually or socially, concerning which advice was sought, and that in every case the improvement could be traced to the work of the clinic. If we take the proportion of those where results are known, 64 per cent of the cases showed improvement.

In only ten of these cases of improvement were the results obtained without the co-operation of the social service department. We can therefore say that without this branch of the work the clinic would have been effective in only ten per cent of the cases seen. This indicates that the clinic is dependent for its success on the social service worker. On the other hand, the purely psychiatric side is of importance, for in each case the patient came spontaneously or was brought because common sense had failed to relieve the situation. This shows that expert diagnosis and advice are of equal importance with the means to carry the advice into effect. Neither the psychiatrist nor the social service worker can be independent of the other if the work for this class of patients is to be successful.

It may not be out of place at this point to remark on the status of the psychiatrist in the community. Until now he has been an individual secluded in an institution, whose knowledge and skill have been available only to those whose mental fortunes have already suffered shipwreck. The time is quickly coming, however, when he must take his place on the same footing with the surgeon or the internist, as the expert in those problems with which medicine and surgery are unable to cope. The experience of this clinic alone is enough to demonstrate that neither common sense nor kindliness is effective in solving these problems, any more than the best of unskilled nursing can aid the sufferer from typhoid fever or pneumonia. It is gratifying, therefore, to learn that the psychiatrist is being recognized, even if it be only by charity organizations. The time will probably soon come when he can hope to earn his living in private practice without hiding behind the title of neurologist or internist. His best work must be done with those who are not insane, but it is the responsibility of all of us to educate the public to realize that no mental abnormality of any grade constitutes a stigma.

The disabilities under which the clinic labors have been mentioned. It is not out of place to suggest what might be done in order to improve the value of this work. In the first place, and obviously, the clinic should be better organized, with more physicians and in better physical surroundings. Above all, there should be more such clinics. They should exist in every city and town. In the treatment of patients certain needs are constantly coming to mind. One of these is for an observation home for children of abnormal tendencies. It is a psychological peculiarity of children that very few of those who have not reached the adolescent stage are capable of consciously formulating their difficulties. For this reason one has to rely on actual observation of the child at play and at work. An observation home for children, therefore, would give trained observers an opportunity for studying these patients in a fairly normal environment, and would make it easy to determine how much of their difficulties was dependent on faulty environment. The ungraded classes furnish desirable treatment for the feebleminded, but they are not adapted to the treatment of the abnormal. For this reason there is at present absolutely no place to turn when one wishes to study and treat the abnormal child.

Another need is felt whenever one has to do with the constantly recurring cases of dependents who are dependent because of constitutional defect or of mild psychoses which make it impossible for them to adapt themselves to the rigorous demands of our intricate modern life, but who can be economically productive if they are in an environment which requires of them less responsibility in adaptation. For these individuals an industrial colony is a crying need, where could be sent alcoholics, mild paranoiacs, and that vast army of indigents who are incapable of finding and keeping employment without supervision, but who are nevertheless capable of much and good work where their tasks can be given them piece by piece, and where they are not called upon to plan their own lives.

The last need that I have to mention is that of greater authority over the homes of those who are mentally abnormal. If a child has committed a crime the state is allowed to remove that child from its environment and place it under such influences as it thinks best. If the child, thanks to the same environment, however, has not been lucky enough to commit some crime, the state can do nothing for it until such time as mental disease may develop in its most aggravated form, and the family petitions for the patient's commitment. Similarly, if a man is brutal in his treatment of his wife the state may interfere, but if he has delusions of unfaithfulness or merely a constantly suspicious attitude, he may make her life, and that of all their children, a continual torture, and yet the state can not intervene. There is, naturally, a limit which must be set in any society to the interference on the part of the state with the independence of the home. But if a psychiatric department were part of the machinery of the court of domestic relations and the juvenile court, if psychiatrists were given an authority commensurate with that enjoyed by the Board of Health in the control of infectious diseases, there are many families that would be made happier, and fewer children would be bred to fill our insane hospitals.

It would not be right to close this paper without mentioning the value of the psychiatric clinic to the physician himself. Most psychiatrists are working in institutions. Many of them are, sad to say, "institutionalized." There is no experience which can prevent this dreadful deterioration more effectively than an active dispensary service. It is not merely that one's clinical experience is broadened; that goes without saying. A more important influence is that of the therapeutic responsibility which is forced upon the physician with each examination he makes. In the insane hospital it is an easy thing to examine a patient, make a diagnosis, and in summarizing the case say that the treatment should be "institutional." In many cases this is, of course, quite justifiable. For of the vast number which are placed under the care of one physician, it is impossible that treatment should be individualized in every case. In the dispensary, however, the responsibility is immediately upon the physician. He must come to a speedy decision, and much may depend upon his advice. Tragedies are often to be averted, and his will be the responsibility, very largely, if the advice be at fault. It is this constant demand for quick and accurate thinking that makes the dispensary experience invaluable to a physician, the bulk of whose work lies in an institution.

THE FAMILY OF THE NEUROSYPHILITIC*

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IT may seem trite to call attention to the problem offered by the family of the syphilitic, as it is recognized by all that syphilis is a contagious disease and that in consequence it is frequently transmitted by the infected person to the spouse and to the children. In spite of this knowledge, however, the problem is largely neglected.

The complete story of syphilis and its ravages cannot be told in a limited space. Suffice it to say that the symptoms of syphilis may occur at any time after the infection even though an individual live a half century, and that syphilis imitates in its symptoms almost every disease. Some of the most frequent and most serious of the syphilitic conditions are cardio-vascular disease, *i. e.*, *early* arteriosclerosis, apoplexy aneurysm, angina pectoris, etc., and diseases of the nervous system, such as general paresis, locomotor ataxia, cerebrospinal syphilis. The latter conditions, due to syphilitic involvement of the central nervous system, are what we include under the term neurosyphilis. General paresis and locomotor ataxia (tabes dorsalis) are always and without exception syphilitic manifestations. Just as without the tubercle bacillus there can be no tuberculosis, so without the spirocheta pallida (the germ of syphilis) there can be no paresis or tabes.

We cannot here consider the mental, physical and moral devastations, the economic and social wastage, the anguish and suffering caused by syphilis in those who have acquired it in adolescent or adult life after nature's defenses have been broken down. Nor can we do more than merely enumerate a few of the terrible consequences passed on to the progeny of the infected. Sterility, abortions, miscarriages, stillbirths and early deaths are among the less terrible consequences of parental syphilis—these potential lives escape the suffering and handicaps of many who are born with congenital syphilis. Feeblemindedness, deafness, blindness, paralyses, deficient development, marasmus, meningitis, and skin diseases are among the early manifestations of congenital infection. Many congenital syphilitics are afflicted only with lessened vitality, anemia, delayed development, irritability, nervousness, neurotic manifestations and the like. Others are apparently healthy, well-endowed children, but during the pubescent and adolescent periods the presence of the disease first makes its appearance, frequently as interstitial keratitis, leading to partial or total blindness, or deafness; or there may appear the symptoms of syphilis of the central nervous system, known as juvenile paresis, juvenile tabes, etc., running through the whole gamut of the conditions produced by acquired syphilis. Many more conditions resulting from congenital syphilis might be added as well as the suspicion that many cases of neurasthenia, hysteria and dementia praecox may be of like cause; but enough has been said to indicate the ravages of the disease.

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*Read at the National Conference of Social Work, Pittsburgh, 1917.

How is it possible that such conditions are allowed to continue almost without challenge? The reasons are several. The greatest of them is ignorance upon the subject, not only of the uneducated public, not only of the semi-informed social worker but also a considerable degree of ignorance on the part of many physicians. This is not an arraignment of physicians; it is only a frank acknowledgment that our information is but slowly accumulating and is still almost entirely in the hands of the specialist. To anyone suffering from syphilis, let us boldly offer the advice that none should be discouraged if his physician disagrees with what is here stated—consult a specialist in syphilis and he will bear out these observations. We can hardly pause to recall the difficulty of lay education on this previously prohibited topic and the physician's hesitancy of betraying in any way the confidence of his syphilitic patient, even to protect another.

But there are other factors to be considered which depend on the very nature of syphilis. After the early symptoms, for a long period of time there may be no evidence to the patient that the disease is active and hence he thinks he is safe. Even though warned by a physician he may disbelieve and marry, or the physician may believe him cured and give consent to marriage, or he may ask no advice, or the future spouse may know and not object to marriage on this trivial score, or the victim of the disease may be ignorant of the fact that he has or had acquired syphilis.

At any rate, as we well know, marriage is entered into by many syphilitics and then arises the problem of the family of the syphilitic. This problem as previously stated is well recognized by all engaged in the study of syphilis. The family of the syphilitic, including spouse and children, have been exposed to syphilis, the spouse exposed to the so-called acquired form, the children to the congenital form. Not all exposed to syphilis acquire the disease —far from it, for at least 75 per cent of all prostitutes have syphilis, and if it were universally infective it would be almost universally widespread. There are certain laws that give us some insight into the infectivity of syphilis, for instance, it becomes less contagious as time goes on; open lesions are usually necessary for its transmission. In the congenital form the ravages grow less as the time from the original parental infection increases. These laws can be found in text-books on syphilis, both medical and for the layman.* But these laws are based on statistics and, while they apply to a group of cases, any particular case under consideration may prove an exception. In other words, there are many exceptions and much that we do not understand, so that every case presents a special problem.

Syphilis in both its acquired and congenital forms is not always easy to recognize. A characteristic of syphilis is that there are long periods of quiescence or latency lasting months and years, during which there are no symptoms that bother the patient or appear on superficial examination. Then five, ten, fifteen, twenty or even forty years of latency is broken by an exacerbation or a cropping out of symptoms—symptoms perhaps easily recognized as syphilitic but recognized often too late for treatment. In other words, latency may only mean the absence of manifest symptoms, while the disease is actively at work in destroying the organism. This period of latency is to be found in nearly every case in which the most serious results occur. Many individuals are not aware that they have acquired syphilis until these late manifestations appear. We have often had patients relate how lucky they had been in avoiding syphilis all their lives, when as a matter of fact they were victims of the disease.

It is during these years of apparent latency that much can be done by treatment to prevent the late symptoms of syphilis and it is for this reason that we desire to discover cases that are existent but unrecognized. On the whole, the earlier treatment is instituted for syphilis, the better the results. But it is not entirely easy to make a diagnosis of syphilis. In the last few years we have been greatly helped by the Wassermann test, but this is not a sufficient and final criterion. There is still much difficulty and much to be learned. But we do know that the most likely field for the discovery of syphilis is the family of the syphilitic patient. Therefore, the modern, well-equipped and well-managed syphilis clinic makes the study of the families of the patients of the clinic an integral part of its service.

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* See William Pusey: Syphilis as a Modern Problem. Chicago: American Medical Association, 1915.

The examination, and treatment when indicated, of the family of the syphilitic becomes one of the greatest services such clinic offers the patient, his family, the community and the nation. As has been said, such plan is being followed today in the majority of syphilis clinics, but unfortunately only a very insignificant percentage of cases of syphilis ever reach the syphilis clinic. Many cases found in other parts of a hospital are not sent to the syphilis room nor thoroughly considered. Many cases are not recognized; many are treated by private physicians; many are in orphanages or with child-helping agencies. The beginning has, however, been made; the problem has been outlined; and many have become initiated into the circle of workers and so the work will increase.

But the problem we have set ourselves is to speak of the family of the neurosyphilitic. After what has gone before, it can be quickly and briefly stated. The problem of the neurosyphilitic's family is the problem of the syphilitic's family. Then why say more? Is it merely an excuse for emphasizing the need of family treatment? That is only partly the reason. It is because it is rarely realized that the family of the neurosyphilitic is the family of the syphilitic. And so, purposely, we reiterate—the family (the spouse and children) of the general paretic is the family of a syphilitic, and the family of the tabetic is the family of a syphilitic. And thus these families become the heirs of all the scourges of the syphilitics, as briefly indicated previously.

To understand why it is necessary even to consider what ought to be a commonplace fact, axiomatic, accepted and acted upon, we must briefly consider the development of our knowledge concerning general paresis, tabes and other forms of syphilis of the nervous system. It must be remembered that the symptoms of the syndromes making the classification of general paresis and tabes occur years after the infection and follow a long period of quiescence or latency, in which the patient is free from gross symptoms. It was not until very recently that these conditions were recognized as syphilitic. At first, a few students of the subject called attention to the frequency with which paretics and tabetics gave a history of syphilis. The suggestion of Moebius, little more than a generation ago, that paresis and tabes were syphilitic conditions in 100 per cent of the cases, met with very great scepticism. But as our information increased and as new tests were discovered, this hypothesis became more and more plausible. It seemed, however, too simple an explanation, too good to be true, as it were, and a loophole had to be found. This was furnished by Fournier, the great French syphilographer, who taught that paresis and tabes were the result of syphilis but were not manifestations of active syphilis, occuring only where syphilis had previously been. He coined the term parasyphilis to cover this conception, and this term is still with us, though we have learned that its original conception was based on a false premise. This idea concerning paresis and tabes as parasyphilitic did much harm in diverting attention from the problems of syphilis, and its damaging influence is still only partially dispelled. It was not until 1913 that the final link in the chain of evidence that parasyphilis is active syphilis was forged by the discovery of spirochetes in the brain and cord of the paretic and tabetic by Noguchi and Moore.

Harmful as was the teaching of Fournier, it had the effect of stimulating men to disprove it, and led to the examination of the families of paretic and tabetic patients for further evidences of syphilis. With the discovery of a serum test for syphilis in 1906 by Wassermann, Neisser, and Bruck, a new aid and a new impetus was given, and since then studies have been made by men in all countries, among whom may be mentioned Nonne, Régis, Haskell, and Hyde. The findings differ only in percentages, varying with standards and methods; all agree that the devastation is great, the menace, serious. Yet, despite the evidence on all sides, we occasionally hear from those who have not themselves thoroughly studied the matter, statements that the children of paretics and tabetics who do not die early grow up into exceptionally fine specimens of humanity. It is because of such statements that we have felt justified in doing more than emphasizing what seems to us so obvious; namely, that spouses and children must be carefully studied for manifestations of syphilis. We therefore give herewith an analysis of our work in the families of syphilitic patients suffering from nervous system involvement, and compare them with those where the central nervous system is not involved.

It is a routine at the Boston Psychopathic Hospital to examine whenever possible the families of all our syphilitic patients. To do this it is necessary to get the spouse and children of the patient to report to our Out-Patient Department. To obtain this end the aid of the Social Service Department is invaluable, and without such aid it would be almost impossible to do the work adequately or efficiently. With such aid the majority of the individuals desired readily co-operate for examination and treatment.

We have thus far examined the families of 247 syphilitics, of which 160 families were of syphilitics suffering from general paresis, 72 of syphilitics without definite central nervous system involvement and 15 with the diagnosis of tabes and cerebrospinal syphilis.

In the 160 families in which one parent was a paretic, 226 individuals were examined. If we consider the Wassermann reaction alone, we find that it was positive in 23 per cent of the group or in 52 individuals. Of these 52 positive Wassermann cases, 33 were spouses and 19 were children suffering from congenital syphilis. It should be mentioned here that the Wassermann reaction is only a part of the examination. Many patients with syphilis give a negative Wassermann reaction. However, it is given preference here as having less error on account of the individual equation in examination and because it is better standardized.

From the 72 families in which one parent had syphilis but no evidence of central nervous system involvement, 91 members were examined. In this group 35 per cent gave a positive reaction, more than one in every three. Of these positive reactions, 13 were found in the mate of the patient and 18 were congenitally syphilitic children.

The group of tabetic and cerebrospinal syphilis families is too small to merit consideration here, further than to say that the figures of syphilitic involvement ran slightly higher than in the other larger groups.

These Wassermann findings rate much higher than in the population at large, where the percentage of positive reactions is given by various investigators as varying from 5 to 15 per cent. In the Psychopathic Hospital the average varies each year between 12 and 14 per cent. In the groups under consideration it ranges from 23 to 35 per cent.

One wishes to know, however, in what proportion of the families this positive finding occurs. It might be that a large number of syphilitics occurred in a few families, thus producing the relatively high percentage. But that is not the case. In the whole group of 247 families, a positive Wassermann reaction was found in 68 families or 27 per cent. In the 160 families of paretics it occurred in 45 families or 28 per cent, while in the 72 families of non-nervous system syphilis it occurred in 19 families or 26 per cent.

It should be borne in mind that the Wassermann findings do not represent the total of syphilitic involvement. In many syphilitics a negative blood Wassermann is obtained. Much of the syphilitic damage is represented by abortions, miscarriages, stillbirths and early deaths. No greater cause of race suicide can be imagined than syphilis. For example, of the group of 247 families, 84 families or 34 per cent were sterile, had no children. Of the 160 families of paretics, 53, or 33 per cent, had no children. In the population at large, the least productive group as to children is supposed to be the college trained. But we find among the Harvard and Yale graduates only from 19 to 23 per cent of infertile marriages in contrast to the 33 per cent among paretics. It was found further, that 20 per cent of the families had abortions, miscarriages and stillbirths, while dead children occurred also in 20 per cent.

As a result we find the average of living children per family to be 1.3, a figure very much lower than necessary to keep the population stable. The figures are about the same for families in which the original patient had or had not nervous system involvement. The birth rate for the 247 families averages 1.7 children. From the United States census report it is found that the average birth rate in our vicinity is 4.4 children per family. But this difference between 1.7 and 4.4 does not tell the whole story. Were it not for syphilis the 4.4 figure would be higher, for that average includes the syphilitics. But of the 1.3 living children per family, many are afflicted with syphilis and will have a shortened life and a lessened efficiency.

To sum up, incompletely, what syphilis has meant to these 247 families, it will suffice to state that only 69, or 28 per cent, showed no defect as to children, 30 per cent in the paretic and 27 per cent in the other group. Only 61 families, or 25 per cent, showed neither defect as to children nor Wassermann reaction. These figures, it seems to us, show unequivocally that the incidence of syphilis is tremendously high in the families of the syphilitic and that it is as high in the families of the paretics and tabetics as in those whose syphilis has not invaded the nervous system.

A few illustrations may be given as concrete instances.

Family 1. A woman came to our attention suffering from general paresis. On examination of the other members of the family it was found that the husband showed the early signs of syphilis of the nervous system. The oldest son was brought to us with juvenile paresis well marked and died four months after first being seen by us. The second son died a month later of ruptured aneurysm, at the age of 20, certainly due to syphilis. The third son had the stature of an achondroplasia. The fourth was a misshapen cripple with caries of the spine, while the fifth son, although in good health, showed stigmata of congenital syphilis. There were three stillbirths.

Family 2. A boy of 14, an only child, was brought to the hospital because he was backward mentally. He was found to have juvenile paresis. The father on examination proved to be in the early stages of locomotor ataxia. The mother was quite deaf, due to syphilitic involvement of the eighth nerve.

Family 3. A man with general paresis had a wife and two apparently healthy children, all three having positive Wassermann reactions.

Family 4. The husband had paresis; the wife showed no evidence of the disease. The older child, aged 6, was feebleminded and had a positive Wassermann reaction; a younger sister, aged 4, was apparently bright and healthy but also had a positive Wassermann reaction.

Family 5. A woman came to us with her two daughters, aged 11 and 9, asking to be examined. Her husband had recently died of general paresis. She had heard that this was a syphilitic disease. From Brieux's *Damaged Goods*, she had learned of congenital syphilis and hence her request for examination. She proved to have a positive Wassermann reaction. The older girl was anemic, underdeveloped, nervous, irritable, and bore the unmistakable signs of congenital syphilis. She had a positive Wassermann reaction. The younger child was apparently well endowed mentally and physically but also had a positive Wassermann reaction.

But why should we make these examinations that show such unpleasant findings? It is in order to help these sufferers from syphilis, who for the most part are innocent and unsuspecting victims. The characteristic of syphilis, mentioned above, to remain dormant or apparently inactive for a long period gives us the opportunity, if we grasp it, to apply therapy before the ravages have, in some instances, gone very far. Hence our desire to make the diagnoses early. Then therapy is of avail. In Family 1, it was obviously impossible to do aught for the first or second son, but probably much could be done for the fifth to keep him from going the path of his older brothers.

In Family 3, we have a striking example of the value of such examinations. Here is a mother and two children who, while apparently healthy, are suffering from syphilis. Treatment applied now may well prevent any future symptoms. The aim of medicine today is first, to prevent disease, and where that is not done, to discover it as early as possible, that treatment may have its greatest chance for success. By diagnosis, made possible by family examination, something can be done to prevent the spread of the disease; much can be done to prevent symptoms, and hope can be offered for healthy children by treatment applied to the parents before the birth of children, and often to the children themselves when no great damage has yet been done by the disease.

It is not our province to point out the methods of diagnosis or treatment. This, in every instance, is highly specialized work for the physician, but it may be well to insist that results of therapy in syphilis, and especially in late and congenital syphilis, can be obtained only after years of treatment, and that the patients must be under medical care probably for life.

To handle the problem properly, education is essential, education of the physician, the social worker and the layman. The value of education of the layman is shown by the illustration (Family 5) in which the mother, through her reading of *Damaged Goods*, sought aid, when such aid had been withheld by physicians who had not done their duty in diagnosing the children as syphilitic.

As an argument against family examinations in syphilitics, it is sometimes said that there is grave danger of breaking up the family if it is learned that one member has syphilis. This is a very weak argument against examination, we should say, if by such examination steps can be taken to eradicate syphilis from the family. But the argument is *entirely* fallacious. In three years' experience with the families of syphilitics and in dealing with more than 250 families, we have not broken up a single family nor, we believe, brought undue unhappiness into any. We shall be able to begin to attack the problem of syphilis only when the knowledge of syphilis and its manifestations and ravages is widespread. To those who fear to tell a man or woman that general paresis and locomotor ataxia are syphilitic diseases, we would give warning that before long this will be as common knowledge as that consumption means tuberculosis. And to those who have withheld this knowledge and allowed syphilis unhindered to reap its harvest, not thanks but rather recriminations will come.

In closing, we would repeat that the families of syphilitics show syphilis in a very high percentage; that the families of paretics and tabetics are the families of syphilitics, and that the families of all syphilitics should be thoroughly examined that treatment may be instituted where indicated.

BETTER STATISTICS OF MENTAL DISEASES

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AT the meeting of the American Medico-Psychological Association, held in Niagara Falls in June, 1913, Dr. James V. May, then medical member of the New York State Hospital Commission, read a paper on "Statistical Studies of the Insane" in which he set forth important facts relative to the patients in the New York State hospitals and made a plea for the adoption of a system of uniform statistical reports by institutions for the insane throughout the country.

Following the discussion of Dr. May's paper, the association appointed a committee on statistics consisting of Dr. Thomas W. Salmon, Medical Director of The National Committee for Mental Hygiene, Chairman; Dr. Owen Copp, Superintendent of the Pennsylvania Hospital for the Insane; Dr. James V. May, medical member of the New York State Hospital Commission; Dr. E. Stanley Abbot, Assistant Physician of the McLean Hospital, Waverley, Massachusetts; and Dr. Henry A. Cotton, Superintendent of the New Jersey State Hospital at Trenton. The work of this committee extended over a period of four years, during which time several meetings were held and the various phases of the problem of securing adequate statistics of mental diseases and of hospital administration were thoroughly discussed.

In its report submitted to the association in May, 1917, the committee states that "the lack of uniformity in hospital reports at the present time makes it absolutely impossible to collect comparative statistics concerning mental diseases in different states and countries, and extremely difficult to secure comparative data relative to the movement of patients, administration and cost of maintenance and additions"; and that the "importance and need of such uniform data have been repeatedly emphasized by officers of the association, by statisticians of the United States Census Bureau, by editors of psychiatric journals and by administrative officers in various states." "Such data," the committee adds, "should serve as the basis for constructive work in raising the standard of care of the insane, as a guide for preventive effort, and as an aid in the progress of psychiatry."

It was evident from the outset that the lack of a generally recognized nomenclature of mental diseases was one of the principal obstacles in the way of securing uniform reports. The committee, therefore, after a careful review of existing systems, prepared a new classification and unanimously recommended its adoption by the association. The classification submitted provides for twenty groups of psychoses and for the subdivision of some of the groups into their well-recognized types. It is largely based on the Kraepelin psychiatry, and in its main outlines is similar to the classification used in New York State since 1908. The committee also submitted forms for eighteen statistical tables, which it believed would give the information that should be annually reported by every state hospital for the insane.

In order to secure uniform statistical reports, the committee recommended that the association appoint a standing committee on statistics, and that such committee co-operate with The National Committee for Mental Hygiene in securing the adoption of the association's classification by federal and state authorities, and in collecting and publishing an annual statistical review of the insane.

The report and recommendations of the committee were adopted, and President Anglin appointed a standing committee on statistics consisting of Drs. Thomas W. Salmon, Owen Copp, James V. May, E. Stanley Abbot, Adolf Meyer, George H. Kirby and Albert M. Barrett.

Following the action of the association, steps have been taken in several states by those interested in the care of the insane to bring about the adoption of the association's classification and system of reports. New York, Massachusetts and Maryland have already taken the desired action, and it is probable that fairly complete adoption of the system will result before the next meeting of the association.

The division of neurology, psychiatry and psychology which was recently established in the office of the Surgeon-General of the Army, has adopted the association's classification and will use it in making diagnoses of mental cases appearing among the soldiers at the various army camps. It is probable that this classification will also appear in the next revision of the Manual of the Medical Department of the Army.

To assure the success of this movement for better statistics of mental diseases, there must be a full measure of co-operation on the part of both governing boards and institutions. The former should adopt the new classification of mental diseases and the new series of forms, and should require the institutions under their control to keep their records in such way that the required data would be available. The institutions, whether under a central board or independent, should make the modifications in their present classification and records necessary to bring them into conformity with the new system.

Wherever possible, the state administrative board in charge of institutions for the insane should establish a central bureau of statistics. Such bureau would receive a statistical card report concerning each patient admitted, discharged or deceased. From these reports the statistician would compile the required tables and then file the cards for future reference and study. This bureau would also receive and compile reports from the hospitals concerning finances, improvements, farm operations, manufacturing, employees, out-patient activities, etc. A statistical bureau of this kind has been in operation in the office of the New York State Hospital Commission during the past nine years. This bureau now has a file of uniform cards of about 50,000 first admissions—the largest collection of systematic data concerning mental diseases in the world. It is now able to study the separate mental diseases in a sufficient number of cases to form the basis for safe statistical conclusions. A study of alcoholic insanity published by the bureau in 1914 comprised 1,729 cases, and a study of dementia praecox now under way comprises 7,026 cases. The comparative data annually prepared by the bureau relative to the administration of the hospitals constitute reference material of great value.

The advantages of a central bureau of statistics over the old system of separate compilation of data by each hospital may be summed up as follows:

1. A central bureau has work of sufficient magnitude to warrant the employment of a trained statistician, while the statistical work at the separate hospitals is usually done by untrained employees.

2. A central bureau compiles the data for all institutions in the same way, and the results may be more safely compared than when compiled in separate institutions.

3. A central bureau is able during a series of years to accumulate a much larger mass of uniform statistical material from which

special studies can be made, than would be possible in separate institutions.

4. The data compiled by a central bureau is more accessible than that compiled by separate institutions.

With central bureaus compiling and publishing statistics of mental diseases in the various states, it would be comparatively easy for The National Committee for Mental Hygiene, in co-operation with the standing committee of the American Medico-Psychological Association, to prepare annually a comprehensive statistical review of mental diseases and of the operations of institutions for the insane throughout the nation as a whole.

That great gain would result from this system of uniform records and reports cannot be doubted. Patients would be more carefully studied, better understood and consequently more effectually treated. The work of one institution would be compared with that of others, and the good results in one would serve as an inspiration to all. The occurrence, nature, course and outcome of the various mental diseases in different sections of the country would become known, and thus a foundation for preventive work would be laid.

A STUDY OF 608 ADMISSIONS TO SING SING PRISON*

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INTRODUCTION

MUCH as we should like to enter into a detailed discussion of case histories in the presentation of this report of the activities of the Psychiatric Clinic at Sing Sing prison during the first nine months of its existence, it is obvious that this course would lead us considerably beyond the scope of the report. What we aim to present in these pages is a bird's-eye view of the nature of the problem involved, rather than a clinical study of criminal types. We have felt from the first that a general view of the problem is most essential before any more or less detailed approach to it of a purely research nature is undertaken. That in the course of gaining this general survey we should have gathered a great deal of useful and interesting clinical material is but natural, but the presentation of this material in detail must await future publication.

To those who have given serious thought to the problem of criminal behavior, there should, of course, be no doubt as to the part psychiatry ought to play in the field of criminology, but if a need is still felt for the outlining of reasons why criminology should seek in psychiatry an aid toward the definition and administration of its problem, the following rather significant facts might be offered for contemplation:

1. Of 608 adult prisoners studied by psychiatric methods out of an uninterrupted series of 683 cases admitted to Sing Sing prison within a period of nine months, 66.8 per cent were not merely prisoners, but individuals who had shown throughout life a tendency to behave in a manner at variance with the behavior

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*EDITOR'S NOTE.—This article is a report of the activities of the Psychiatric Clinic at Sing Sing prison from the time of its establishment, August 1, 1916, to April 30, 1917. Through the financial support given by the Rockefeller Foundation, the National Committee for Mental Hygiene was enabled to undertake the planning and supervision of this work. The report in full, together with acknowledgments of the credit due to those who have assisted in the successful operation of this clinic, will be published by the National Committee for Mental Hygiene and may be obtained upon application.

of the average normal person, and this deviation from normal behavior had repeatedly manifested itself in a criminal act.

2. Of the same series of 608 cases, 59 per cent were classifiable in terms of deviations from average normal mental health.

3. Of the same series of cases, 28.1 per cent possessed a degree of intelligence equivalent to that of the average American child of twelve years or under; of the ninety-eight native-born defectives, 80.6 per cent were recidivists* in crime, whose average number of sentences to penal or reformatory institutions was 3.5; and 85.7 per cent of the group will have been returned again into the general community within a period of five years.

4. Of the 608 cases 18.9 per cent were constitutionally inferior, or psychopathic, to so pronounced a degree as to have rendered extremely difficult, if not impossible, adaptation to the ordinary requirements of life in modern society. This lack of capacity for adjustment is reflected, on the one hand, in the fact that of the ninety-one native born in this group 86.7 per cent were recidivists in crime, whose average number of sentences to penal or reformatory institutions was 3.9, and, on the other hand, in the fact that a very significant number of them have been total economic failures thus far. Furthermore, 82.4 per cent of these cases will have been discharged again into the general community within a period of five years.

5. Of the 608 cases 12 per cent were found to be suffering from distinct mental diseases or deteriorations, in a considerable number of whom the mental disease was directly or indirectly responsible for the antisocial activities.

The above cited facts strongly support the opinion that one is dealing here with a highly selected and highly specialized group of human beings. But, we might add that, according to an estimate made for us by the Federal Bureau of the Census, the 683 cases admitted to Sing Sing within the specified nine months constituted but .029 per cent of the total male population of over sixteen years of age of the counties from which Sing Sing derives its prisoners—683 out of 2,343,087.

It should be obvious from the foregoing that it would be futile to expect any uniform machinery, no matter how perfect such might be, to be equally applicable to all of the individuals embraced within this group of 608 cases, and that a more hopeful solution of the problem might be expected from a more intensive individualization in the administration of it.

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* A recidivist is an individual, who, in addition to his present term of imprisonment, has served one or more previous sentences in penal or reformatory institutions. Page 100.

To the student of behavior, a knowledge of the individual back of a given act is considered absolutely essential if a clear understanding of the nature of behavior is to be had. Nevertheless, one cannot escape the conviction that as far as the administration of the problem of crime is concerned, the man back of the act is largely lost sight of, and what is actually administered is the criminal act and not the criminal. Intimate contact with the problem of crime inevitably leads to the opinion that every agency concerned in the administration of this problem sees in its own work an end in itself, and seems to lose sight of the common goal or end, toward which all should be striving, namely, the readjustment of that badly adjusted individual, the criminal.

That this cannot be expected to be otherwise under the prevailing attitude of the average community toward its problem of crime must be obvious to any one who takes the trouble to look into the situation more closely. Just as long as a community will judge the efficiency of its police officers, its prosecuting attorneys, and its judiciary by the volume of crime they are able to detect and punish, rather than by the extent to which they succeed in preventing crime, an unnecessarily large number of what might be termed provoked crimes must be the result.

The manner in which the problem of any individual criminal is handled before he is admitted to prison, must of necessity affect the degree to which the institution will succeed in accomplishing what is perhaps the most important of its functions—the return to the community of a better man than it originally received. To expect any institution, penal or reformative, to accomplish this in all cases, in view of the constitutional make-up of so large a part of the constituency of the average prison, would be well nigh expecting the impossible. But if the reformative institution cannot accomplish this result, it loses very much of its usefulness as an agency for the administration of the problem of crime, and some other method must be resorted to in those cases in whom periodic imprisonment fails to produce the desired result.

There is no reason to believe that Sing Sing is unique in respect to the number of recidivists that it harbors (66.8 per cent of its total population). Nevertheless, it finds it mandatory to return to the general community within a period of five years 85.7 per cent of a group of prisoners, of whom 80.6 per cent are recidivists with an average record of 3.5 sentences. Because of the importance of the manner in which the prisoner has been handled before coming to prison, in any attempt to estimate his chances of reformation, it is very desirable that the agitation which one meets on all sides for reform in this important social problem should occupy itself with the agencies which handle the prisoner before his arrival in prison, as much as it concerns itself at present with prison reform.

I have in mind a hardened and thoroughly experienced burglar who has already served in penal institutions on a number of occasions. He deliberately tells me that he has no intention whatever to do anything but thieving upon his release from his present term of imprisonment and disdainfully refuses the offer of help which might tend to change his mode of living. Yet we are compelled by law to release this man from prison within a few weeks, because his sentence expires; not that there is a lack of adequate legal provision for the proper administration of cases such as his. A New York state law provides for the administration of so-called habitual offenders; but we have seen many prisoners constitutionally inclined to criminal behavior, who had already served as many as seven or eight sentences in penal institutions, readmitted to prison on a definite sentence of two or three years. Inquiry into the reasons for this reveals the unsavory fact that the prosecuting attorney, to whom the man's criminal record is well known, deliberately enters into a bargain with, for example, the seventh offender to plead guilty as a second offender, in return for which the habitual criminal escapes with a definite sentence of two or three years. That this deliberate participating in a crime through sanctioning a perjury on the part of the offender serves neither to protect society nor to instil into the criminal a respect for the law, should be perfectly obvious. Instances of this nature are not at all rare in our experience at Sing Sing.

In emphasizing the constitutional factors which are responsible to so large a degree for antisocial behavior, the psychiatrist must not fall into the very serious error of ignoring the many environmental factors which contribute directly or indirectly to the commission of crime. These factors are not confined entirely to those natural phenomena of heredity and environment which so many of us cannot escape, but embrace also the many artificial conditions created by society in its endeavor to administer the problem of crime, conditions with which the criminal is bound to come in close contact in the course of his criminal career. That certain gross defects in each and every one of the various phases of the machinery of the criminal law are responsible to a greater or lesser degree, if not in the creation of a criminal career, at least in the continuance of it, cannot be doubted once the results are more closely scrutinized. It would be extremely interesting, and perhaps profitable, to enter into more detailed discussion of the influences which these vicious institutional factors have on the volume of crime, but it is preferable for the present to stress more particularly the constitutional factors in crime. In omitting for the present detailed reference to this phase of the problem, it does not mean that we have not been alive to the issues involved. It would, indeed, be very unfortunate if the psychiatrist were to make a conscious effort to avoid referring to the various obvious and unnecessary fallacies with which criminal procedure is still permeated. The mere establishment of the fact that so many criminals are defective, or insane, or psychopathic, will not aid materially in the solution of the problem of crime, if one remains blind to the various environmental factors, physical as well as social, which are responsible for criminal behavior. Because an individual is defective, or insane, it does not mean that he is also destined to be criminal. There are unquestionably many more defective and insane people outside than within prison walls. But an unintelligent and sometimes vicious administration of the defective, or insane, may well serve to make criminals of them, and to that extent, at least, the psychiatrist's concern with problems of administration is not only justified but imperative.

CLASSIFICATION

In the introduction, we have indicated, by means of statistical data, the impression one is likely to receive from a general survey of a prison population such as is found at Sing Sing, but, as we have already stated, lack of space prevents our entering into a detailed presentation of case histories, and this must await a more purely clinical presentation of our findings.

In classifying our material into various groups, we did not enter, for obvious reasons, into the finer, diagnostic differentiations. What is needed first of all is a general outline of the problem which will make possible a more rational administering of the prison situation, for example, of a state like New York. Thus, we have classified our cases as follows: (a) The Intellectually Defective

Group; (b) The Mentally Diseased or Deteriorated Group; (c) The Psychopathic Group, and (d) The Unclassified Group.

That a finer differentiation of types will be possible when we come to a purely clinical presentation of the subject cannot be doubted, and in one instance, at least, we are almost certain to be able to add an additional group—the Epileptic Group. As a matter of fact in the 608 cases studied, only two cases were classifiable as definitely suffering from epilepsy. Even in these two cases, the original mental defect was so prominent that we felt it advisable to include the two with the mentally defective. On the other hand, we have frequently felt in studying a case that we were dealing with a temperament, or make-up, which, if not definitely epileptic in character, certainly was very closely allied to the epileptic constitution.

Under the Intellectually Defective Group were placed all cases who had shown, as a result of a study of their life histories, a general incapacity to adjust themselves to the ordinary requirements of life, which incapacity appears to have been based largely, if not wholly, upon a general retardation in mental development, and which retardation was capable of definition by means of laboratory study. None of the cases included in this group had reached a degree of intelligence beyond that of the average American child of twelve years, and in a considerable number of cases the intelligence was much lower. It is not easy, as we have already indicated, to define the precise relationship between mental defect and criminal behavior in every instance, but the evidence tends to be cumulative that, inasmuch as criminal behavior is the resultant of the interaction between a particularly constituted individual and a particular environment, environmental factors play a significant rôle in determining criminal behavior, even in the defective. This general opinion may be expressed with reference to all the psychopathologically classifiable types.

The Mentally Diseased or Deteriorated Group includes cases in which evidence came to light of a change in personality, as well as of more or less distinct and well-defined delusional formations and hallucinatory experiences, which findings had their basis in either a mental disease or a deteriorating process. As will be seen in the more detailed discussion of this group, dementia praecox and conditions closely allied to it contributed chiefly to the group. A more detailed study of the relationship between the personality changes involved in this disease and criminal behavior is being contemplated.

The Psychopathic Group—the most difficult to define—constitutes beyond a doubt, the most baffling group in our classification. Because it is often so difficult to convince the layman, or even the physician, that one is dealing here with a distinctly abnormal personality, a clearer definition of this form of deviation from normal mental health is very much needed. Our diagnoses were based upon a study of the life history and mode of reaction which these individuals exhibited in their various contacts with society. That we have probably not erred to a very large extent in diagnosing the individuals belonging to this group may be seen, for instance, in the fact that the average number of sentences to penal or reformatory institutions per psychopathic recidivist is 3.9, and that 23.07 per cent of them have had more or less habitual recourse to the use of narcotic drugs. The industrial careers in most instances were anything but successful, and the entire life picture which the average case in this group presents cannot fail to give one the distinct impression that he is dealing here with a decidedly abnormal type.

The Unclassified Group embraces all cases which could not be classified within any of the three preceding groups. It does not mean, of course, that we are dealing here with what is generally considered to be a normal human being. It simply means that our knowledge concerning a great many of the individuals embraced in this group is still so deficient as to make it unwise at this time to classify them definitely. It is our belief that a more intensive clinical study of these now unclassifiable cases will throw a good deal of light on the causative factors in criminal behavior.

Our chief concern, however, at this time, is to point out, if possible, to what extent a psychiatric approach might aid in the administration of the problem of crime, and for this reason it is unwise to enter into a detailed discussion of any but the clearly definable and recognizable types of offenders.

GENERAL STATISTICAL CONSIDERATIONS

It has been the aim of the clinic, since its establishment, to examine all admissions, without selection, in order that our data might be fully representative of the types of prisoner admitted to Sing Sing. Certain unavoidable omissions, however, occurred, especially during the first few weeks of the clinic's existence, so that of the 683 adult male prisoners admitted to Sing Sing between August 1, 1916, and April 30, 1917, inclusive, only 608 were examined by the clinic.

Of the 608 cases, 359, or 59 per cent, were classifiable in terms of deviation from average normal mentality, as follows:

	Number	*Per cent*
Mentally diseased or deteriorated	73	12.0
Intellectually defective	171	28.1
Psychopathic, or constitutionally inferior	115	18.9
	359	59.0

TYPE OF OFFENSE

In estimating this point, there seems to be no valid reason for following the legal classification. This classification is frequently not in accord with the actual nature of the crime, as is the case, for example, when a man who has committed rape is permitted to plead to assault. Furthermore, the legal classification, already extensive, is growing constantly with the addition of new legislation, so that data obtained today may lose in value by tomorrow. It has been found, on the other hand, that as a result of the examination carried out in these cases, a classification on the basis of motive was possible in practically all instances, and the inception of the motive could be traced to one of the several fundamental human, instinctive attitudes.

In accordance with this biological classification, the following was ascertained:

	Number	*Per cent*
Crimes having their impulse in the instinct of acquisitiveness	388	63.8
Crimes which had their impulse in the instinct of pugnacity	148	24.3
Crimes which had their impulse in the instinct of sex	60	9.9
Perjury	1	2.0
Dynamiting	4	
Aiding escape of prisoner	1	
Arson	3	
Abandonment of children	3	
	608	100.0

While the above table shows nothing beyond the fact that the acquisitive crimes were by far the most frequent in the 608 cases, and that the frequency of a given type of offense is in inverse ratio to its seriousness, a further analysis of each group reveals the following:

Crimes of an Acquisitive Nature

Of the 388 cases, 127, or 32.7 per cent, were of foreign birth, while 261, or 67.3 per cent, were native born. Furthermore, of the 388 cases, 222, or 57.2 per cent, were classifiable in terms of psychopathological deviations, as follows:

	Number	*Per cent*
Mentally diseased or deteriorated	50	12.9
Intellectually defective	96	24.7
Psychopathic, or constitutionally inferior	76	19.6
	222	57.2

Of the 388 cases, 281, or 72.4 per cent, were recidivists; that is, according to our method of determination, individuals who have served one or more previous sentences in penal or reformatory institutions.

Crimes of Pugnacity

Of the 608 cases, 148, or 24.3 per cent, were sentenced for crimes of this nature. Of the 148 cases, 87, or 58.8 per cent, were classifiable in terms of psychopathological deviations, as follows:

	Number	*Per cent*
Mentally diseased or deteriorated	13	8.8
Intellectually defective	49	33.1
Psychopathic, or constitutionally inferior	25	16.9
	87	58.8

Of the 148 cases, ninety-three, or 62.8 per cent, were recidivists.

The Sex Offender

Of the 608 cases, sixty, or 9.9 per cent, were sentenced for sex crimes, as follows:

	Number	*Per cent*
Rape	27	4.5
Sodomy	16	2.6
Bigamy	9	1.5
Abduction	4	1.3
Incest	3	
Seduction	1	
	60	9.9

Of the sixty cases, forty-two, or 70 per cent, were classifiable in terms of psychopathological deviations, as follows:

	Number	Per cent
Mentally diseased or deteriorated	10	16.7
Intellectually defective	25	41.7
Psychopathic, or constitutionally inferior	7	11.6
	42	70.0

Of the sixty cases, twenty-seven, or 45 per cent, were recidivists, in our sense of the term.

Thus it will be seen, that on the one hand, the frequency of an offense is in inverse ratio to its seriousness, while on the other hand, the extent of psychopathologically classifiable cases is in direct ratio to the seriousness of the offense. Thus:

Acquisitive crimes psychopathologically classifiable	57.2%
Crimes of pugnacity psychopathologically classifiable	58.8%
Sex offenses psychopathologically classifiable	70.0%

One would expect to find a similar relationship between the degree of delinquency and the extent of psychopathologically classifiable cases. This relationship actually does come to light when we consider the defectives and psychopaths, where the percentage of recidivism was 80.6 per cent and 76.7 per cent respectively, but it also becomes evident in considering our material from the standpoint of the type of offense, as soon as we analyze more closely the relationship between recidivism and the nativity of the offender.

RECIDIVISM

In estimating the degree of recidivism in a given case, two methods may be employed. On the one hand, one may base one's judgment upon the frequency with which an individual has been found to have come in conflict with the law. This method, while it would not throw light upon those individuals who harbor distinctly antisocial tendencies, but who, because of certain protective environmental agencies, manage to escape actual conflict with the law, would be the more desirable method if police records were more reliable than they actually are, or, if "arrest" really meant in each instance a breach of the law. Unfortunately, neither are the police records absolutely reliable, nor is "arrest" entirely confined to those actually guilty of crime. If the latter were the case, the present provisions for the housing of the criminal would have to be enlarged a hundredfold, at least. The second method, and the one which we have adopted for the determination of the factor of recidivism, is based upon the history of previous sentences to penal or reformatory institutions. This method, too, is subject to error, and does not tell a complete story; but the error involved is certainly not so great as that involved in the first method. At any rate, our figures on recidivism may not be extensive enough, but they are dependable as far as given.

Of the 608 cases studied, 406, or 66.8 per cent, had served sentences in one or more penal or reformatory institutions before. Extremely significant is the factor of nativity as far as recidivism is concerned. While the recidivism in the entire group was 66.8 per cent, in the foreign born it was only 49.8 per cent; while in the native born it was 75.9 per cent. This decidedly lower percentage of recidivism in the foreign born is undoubtedly due to the fact that accidental environmental factors play a much greater rôle in the foreigner's conflicts with the law. Ignorance of American customs and laws contribute not a small share of this accidental factor, while exploitation at the hands of unscrupulous members of the same nationality, and others, not infrequently leads the ignorant immigrant to react in an antisocial manner. It would seem that contact with the law and penal and reformatory institutions accomplishes much better results in the foreign born than it does in the native born. If we take into account the degree to which the factor of nativity influences our figures, we shall find that there is also a direct correlation, not absolute but relative, between the degree of delinquency and the extent of psychopathological deviations, even when we classify the material according to type of offense.

There were 213 foreign born out of the 608 cases, or 35 per cent. In the acquisitive group, where the percentage of psychopathologically classifiable cases was the lowest, the percentage of recidivism should also have been the lowest, but we find that, as a matter of fact, it is the highest of the three groups—72.4 per cent. On the other hand, we also find that the influence of the factor of nativity plays the smallest rôle in this group, since the percentage of foreign born to the total is only 32.7 per cent, or less than their percentage in the entire 608 cases.

In the pugnacity group, the percentage of recidivism should have been somewhat higher than it was in the acquisitive group, because the percentage of the psychopathologically classifiable cases was also higher. We find, however, that it is actually lower—62.8 per cent, as compared with 72.4 per cent; but we also find that the percentage of foreign born in this group was also higher—38.2 per cent as compared with 32.7 per cent.

In the sex group, which should have shown the highest rate of recidivism, because of the highest percentage of psychopathologically classifiable cases, we find, on the contrary, the lowest percentage of recidivism—45 per cent—but we also find the highest percentage of foreign born among this group—43.3 per cent.

The following table demonstrates these various relationships:

Crime	Psychopathological classification	Recidivism	Foreign born
Acquisitiveness	57.2%	72.4%	32.7%
Pugnacity	58.8%	62.8%	38.2%
Sex	70.0%	45.0%	43.3%

In any psychopathological study of the offender, the error must be avoided of seeing the cause of the criminal act entirely in the constitutional make-up of the individual. That such is not the case does not require much proof. The criminal act, in every instance, is the resultant of the interaction between a particularly constituted personality and a particular environment. Because 59 per cent of the total number of cases examined were classifiable in psychopathological terms, it does not at all mean that these individuals were predestined to commit crime. In fact, there are, in all probability, many more psychopathologically classifiable people outside of prison than there are within prison. That more of them do not get into prison is due to the fact that they have had the many benefits of suitable environment and the protection which goes with these benefits, a protection of which those who do get into prison have been deprived to a greater or lesser extent. It seems from our study, that environmental features play a greater part in crime among the foreign born than they do among the native born, and this seems to account largely for the fact that while numerically the foreign born constitute a serious problem in our 608 cases, they are far less of a problem in recidivism than are the native born. It is because of our conviction that environmental factors play a much greater rôle in the case of the foreign born, that we feel justified in assuming, as we do above, that there is a correlation also between the degree of recidivism and the extent of psychopathologically classifiable cases even when we classify our material in accordance with the type of offense.

Had it been possible to carry out the type of field investigation in the foreign born that we were able to carry out in the native born, we should have had ample proof to justify our contention. In a separate section, the question of the foreign born is gone into in greater detail.

AGE AT COMMITMENT

The ages at the time of commitment to prison in the 608 cases ranged between sixteen and sixty-eight, the most frequent age being twenty-three. In the foreign group, the most frequent age was twenty-seven.

RELIGION

	Number	*Per cent*
Those professing the Catholic faith	309	50.8
Those professing the Protestant faith	180	29.6
Those professing the Hebrew faith	104	17.1
Greek Catholics	7	1.1
Mormon	1	0.7
Christian Science	1	
Buddhist	1	
Freethinker	1	
No religion	4	0.7
	608	100.0

CIVIL CONDITION

	Number	*Per cent*
Single	356	58.6
Married	230	37.8
Widowed	20	3.3
Divorced	2	0.3
	608	100.0

THE DEFECTIVE GROUP

Of the 608 cases studied, 171, or 28.1 per cent, were diagnosed as intellectually defective. In arriving at the diagnosis of mental deficiency, the current psychometric methods in vogue were employed; more specifically, the Yerkes-Bridges Point Scale, the

Terman Revision of the Binet-Simon Tests, and a number of the Healy Construction Tests. But while we have recognized both the convenience and usefulness for comparative purposes in defining the mentality of these cases in terms of mental age, it will be seen that considerable dependence was placed, in arriving at the final diagnosis, on the individual's life career and on his ability, or lack of ability, to adapt himself to the various demands made upon him.

The diagnosis of mental deficiency, therefore, as herein set forth, does not rest solely on the laboratory findings, but, in addition, takes into account the actual capacity for adaptation which each individual manifested in his past life.

It will be seen later, that the majority of these cases had shown throughout life certain definite traits which would have justified their being considered at least as representing a special problem to society. That failure to recognize this special problem at more than one point in the individual careers of these cases has contributed to a very large extent toward the fact that they are still at present far from being properly adjusted, cannot be doubted. This criticism should, perhaps, apply especially to that highly developed social agency—the public school—inasmuch as in a great number of instances distinct pathological traits were manifested by these individuals during their school careers.

A more detailed and intimate study of the problem of mental deficiency as related to crime, and one which naturally cannot be resorted to here, will aim to determine, if possible, what particular traits in a defective are especially responsible for his antisocial tendencies, and what errors in procedure, on the part of society during the early life of these men, may have played a part toward making them what they are.

There can be no escape from the conviction, that no matter how great the urgency might be for doing everything possible to readjust the adult offender at the time of his contact with a state prison, not much success can be hoped for in a great many instances at this advanced stage of maladjustment. The time for an active effort on behalf of these people is, in the majority of instances, in the past, and if it is true that no opportunity can be had in many cases to apply readjustive measures before they reach the public school, there can be scant excuse for ignoring this serious problem during their contact with the public school. One cannot over-emphasize this point after a perusal of the life histories of these cases, as the impression is frequently gained that a different career would have resulted had there been a more intelligent appreciation of the problem in the past.

The 171 cases comprised all of the defectives among the 608 cases studied; but, inasmuch as our sources of information in the cases of the foreign born were not so complete as we might have wished them to be, the detailed consideration of the problem of defectiveness will be confined here to the native born, of whom there were ninety-eight cases, or 57.3 per cent of the defective group. As has been already stated elsewhere, a detailed consideration of the foreign-born inmates is taken up in a later section.

The chronological age in the native-born defectives was in no instance less than sixteen, and the most frequent age was nineteen. According to the psychometric estimation, the mental ages are represented as follows:

Equivalent to the mental age of the average American child of nine years, or under	5
Of between nine and ten	21
Of between ten and eleven	14
Of between eleven and twelve	58
	98

It will, therefore, be seen that if the mental age is to be taken as a criterion, comparatively few cases might be classed as rather profoundly defective; that is to say, as coming within the classification of the low grades of feeblemindedness, while the majority fall within the various grades of moronism. These findings are particularly significant, inasmuch as they demonstrate that it is the higher grade of defective who constitutes the most serious problem in antisocial behavior. It is frequently very difficult, and sometimes impossible to convince the lay mind, or the jurist, that one is dealing here with mental defect, since many of these cases make good superficial impressions. There seems to be a general tendency to ignore the very natural phenomenon, that the more profound the mental defect, the less likely is the individual to lead a totally unsupervised life, in consequence of which there is also less likelihood of conflict with environment. It is largely in those cases where neither the relatives nor acquaintances of the defective appreciate that there is here a serious difficulty which requires attention—that is to say, in the various grades of moronism—that the problem of criminality looms large.

Notwithstanding the prevalent criticisms of the efficacy of the psychometric method in estimating degrees of intellectual development, it is surprising how close the correlation is between the mental defect as defined by psychometric methods and actual performance as gained from a study of the life histories of these cases. The more one works with these methods, the more one is impressed with their utility as an aid to diagnosis. Furthermore, as far as our own material goes, we should feel no hesitancy in agreeing that at least all those cases who did not reach a mentality beyond ten years of age, ought to be more or less permanently segregated.

RECIDIVISM

In dealing with defective delinquents, one of the most important questions to be determined is the extent to which the tendency to criminal behavior is developed in a given case. It is not very easy to estimate this factor, and we have already outlined the basis upon which we determined the degree of recidivism in a given case.

We have drawn attention to the fact that the estimate of the extent of recidivism among the prisoners at Sing Sing must of necessity be a very conservative one, when it is based solely on former sentences. There is an urgent need for carrying out more intensive studies of methods of determining criminal tendencies in individuals before they are classified as criminals by the police. In this connection, Dr. Walter E. Fernald's insistence upon a clearer definition of the "defective delinquent" deserves the support of everyone.

According to our method of approach, we mean by a "recidivist" an individual, who, in addition to his present term of imprisonment, has served one or more previous sentences in penal or reformatory institutions. Obviously, this does not take into consideration the extent to which the individual may have been in conflict with the law. That this necessity of confining ourselves to those who have served previous sentences, leaves out of consideration the previously unconvicted antisocial individual, and vitiates to a certain extent our statements concerning recidivism, we are fully aware, and this is especially illustrated by the following case, whom we have, in accordance with our method, classified as a "first offender":

This twenty-six-year-old Irish-American, has been on several occasions in conflict with the law for serious offenses, but not until one of these terminated in a homicide has he been convicted and sent to prison. His father, an excessive alcoholic, died of tuberculosis when the inmate was about eleven years of age. One sister has hysterical or epileptic seizures; one paternal uncle was very wayward, and a cousin has had some form of meningitis.

The inmate was born in Brooklyn, New York, 1891, the third in sequence. He was subject to nocturnal enuresis until six or seven years of age, and following an attack of diphtheria, at the age of nine, stuttered for several weeks. He attended the grammar school between seven and eleven, reaching the fifth grade. His industrial career has been extremely irregular and inefficient. Since leaving school, he has held about twenty different positions, and for about three years did nothing in the nature of honest work towards his support.

He has been arrested twice for assault, and once for having been involved in a shooting affray, but each time was released without further ado, and at present is serving a sentence of from five to ten years for manslaughter in the first degree. It appears that during a war between two gangs, he armed himself with a gun, and when he met his opponent, fired at him and killed him.

He is married and has one child. He is of rather low degree of intelligence, reaching a mental age of eleven and nine-tenths years, according to a psychometric estimation. He is deteriorated emotionally and is indifferent concerning his stay here, except that he realizes that he got off lightly. In addition, he shows a number of neurological signs, such as, unequal pupils, exaggerated knee jerks, tremors of the tongue, speech defect and coarse tremors of the fingers; although the Wassermann of the blood serum is negative.

There is no doubt that this case should be considered among the recidivists, notwithstanding the fact that he is serving his first sentence at present. One feels strongly that he is dealing here with a defective delinquent, who, by the way, will again be returned to society, after the expiration of his minimum sentence of five years.

In accordance with our method of classification, seventy-nine cases, or 80.6 per cent of the native-born defectives, have served one or more previous sentences in penal or reformatory institutions. Compared with the general percentage of recidivism in the 608 cases, which was 66.8 per cent we find here an increase of 13.8 per cent—a rather significant correlation between mental defect and tendency to antisocial behavior. A more detailed inquiry into these cases reveals the following:

24 are serving their second term
23 " " " third "
15 " " " fourth "
8 " " " fifth "
3 " " " sixth "
4 " " " seventh "
1 is " his eighth "
1 " " " ninth "

The average per individual was 3.5 sentences, and it would be difficult, indeed, to escape seeing in this high factor of recidivism strongly corroborative evidence of the laboratory diagnosis of mental deficiency.

AGE OF FIRST COMMITMENT

In those in whom this could be determined, the age of first commitment to a penal or reformatory institution was as follows:

At the age of	*Number*	*At the age of*	*Number*
7	1	18	3
9	1	19	8
10	3	20	3
11	3	21	3
12	3	22	1
13	2	23	1
14	5	24	3
15	2	25	2
16	6	30	1
17	4	32	1

Thus it will be seen that in forty-seven cases of those in whom this point could be determined, the first arrest took place before the inmate had passed his twenty-first year of life. Of the seventy-nine cases, forty-six, or 58.2 per cent, had been confined on one or more occasions in a juvenile reformatory institution. Of these, thirty-one were at one time inmates of the State Reformatory, at Elmira. This institution is singled out because we have been particularly struck with the remarkable degree of accuracy of prognosis that its records indicate. In practically every instance, the fact that the individual was very likely to continue to be antisocial, was emphasized in the case record. What a serious indictment of procedure is to be seen in this total indifference to predictions based upon scientific investigation, as was done for instance in the following case:

S. R., a nineteen-year-old Italian-American, was admitted to Sing Sing on a sentence of three years and five months after having confessed to burglary in the third degree. The boy is the issue of illiterate and primitive Southern Italians, the parents having immigrated to the United States about thirty years ago. The father, whose occupation was that of porter and bootblack, died several years ago of pulmonary tuberculosis. The mother is still living, somewhat invalided from rheumatism. An older brother, a confirmed criminal, has been in frequent conflict with the law and is also a drug addict. Another brother suffers from chronic headaches, is quite impulsive and explosive in conduct, frequently changes places of occupation, and was arrested once on suspicion. Still another brother has the reputation of being unusually sullen in his general attitude.

The inmate grew up under very miserable home conditions and without any rational supervision. The family always lived in poor, cramped quarters, in the congested section of the lower East Side of New York. Usually the entire family of parents and eight children occupied two rooms, never more than three. The father's work as porter in a saloon, kept him away from home from early morning until late at night, and he had very little opportunity to supervise the children. Home offered no attractions to the children and from an early age they found unsupervised recreation on the streets of the lower East Side. The mother was attended by a midwife during confinement with inmate; labor normal. His infancy and childhood appears to have been uneventful. He entered school at the age of six and continued steadily until the age of eleven, when he had reached 5-B grade. For some time before this, however, relatives and neighbors began to notice certain changes in his character. He became disobedient, untruthful, dishonest and secretive. He was easily led by other boys, but his parents had absolutely no control over him, especially since the age of eleven. At this time he became rebellious at school, truant, and finally had to be placed in the truant school.

Aside from this change in behavior at home and at school, the boy had been associating for some years before, in fact since the age of about seven, with a set of wild and antisocial boys in the neighborhood, and his record with the Society for the Protection of Cruelty to Children dates from June, 1908, when he was but ten years of age, and when his first arrest for theft took place. He was committed to the Catholic Protectory where he remained until May 12, 1911, when he was placed on trial with his mother. Several months later it was reported that the boy had given up old companions and that he remained at home most of the time, but was ungovernable, displaying bad temper when brought to task. He yelled at the top of his voice, jumped up and down, and generally created such a disturbance as to have annoyed neighbors who threatened to move. The janitress as well as other tenants accused the boy of going to the roof and throwing stones down on tenants or any one passing through the yard. The family was threatened with dispossession unless something were done with the boy. The boy was interviewed at this time by a parole officer from the Catholic Protectory and was told that if his misbehavior should lead to a recommitment to that institution, he would have to be kept until the age of twenty-one. He promised to do better, but did not impress the officer as being sincere. In October of the same year, however, the boy was arrested at the instigation of his father, who complained that the boy was wild and beyond control of the family, that he remained away from home most of the time, and was constantly getting into trouble. His school record at this time was very bad. The boy was placed on probation for about a month. Nothing definite of record happened until March 30, 1912, when he was recommitted to the Catholic Protectory for theft, running the streets and fighting. It is noted that his parents lived at this time in two filthy rooms, and could not manage the boy at all who was already then beginning to terrorize the household. At one time he stabbed his sister in the arm in a fit of rage, and since previous discharge from the Protectory, had been arrested three times for theft. The institution physician at that time, said that the boy was suffering from trachoma. The boy was again allowed out on trial on July 5, 1913, was given his working papers, and promised to obtain work and behave himself well. The father at this time had become a helpless invalid, and conditions at home were much more distressing, but the boy apparently was but little impressed with the situation, resumed his former habits of a wild, ungovernable street life, and in September of the same year had to return to the Protectory again at the solicitation of parents and neighbors. In February, 1914, he was again released on trial from the Protectory, but after two weeks' steady work, resumed his former habits, began to steal more boldly and excessively, and in June of the same year was sentenced to the State Reformatory at Elmira for burglary. His industrial career up to this time was naturally very defective, irregular, and unproductive, since he had spent most of the time from the age of eleven at the Catholic Protectory.

It is highly significant that up to the time of his sentence to Elmira at the age of sixteen, no effort had been made to define in any rational or helpful manner the extremely serious problem which this youngster presented. While our field investigator was able to obtain a fairly accurate record of his behavior at home and in his unsupervised street life, no helpful information concerning his difficulties and behavior at school and at the Protectory is at hand. It would seem that at school at least, this difficult and troublesome boy should have led to a more intelligent attempt to understand the problem he presented than mere transfer to the truant school. It is only as a result of his contact with Elmira that we began to get evidence of an intelligent effort to understand this troublesome personality. Here he is described as a coarse type of Italian, native of New York, weight 122 pounds, 4 feet 2⅛ inches tall, of poor mental capacity, poor susceptibility, and of poor physical condition. He lost ten of the fifteen months of his incarceration there for misconduct involving disobedience of orders, assault, malicious disturbance and damaging state property. A moron with physical stigmata whose extremely low mentality caused him to be placed in their special training class for mental defectives. Finally his condition gave evidence of the gradual development of mental disorder, and on November 5, 1915, he had to be transferred to the Dannemora State Hospital for the criminal insane. The prognosis rendered at Elmira was, "Outlook for improvement *nil;* absolutely no progress in school or labor; a turbulent, vicious, degenerate, whose criminal character will probably cause continuous confinement in penal institutions."

At Dannemora his behavior was better and he was discharged from that institution at the expiration of his sentence, December 6, 1916, as recovered. The diagnosis was, "mentally deficient, paranoid trend." Then while the subsidence of the acuteness of the medical problem which this boy presented, may well have justified the termination of his residence in a hospital for the insane, the woeful lack of appreciation of the serious social problem involved deserves note. Not that the authorities at Dannemora necessarily failed to estimate the gravity of the situation, but that there is still lacking proper legal provision for a more indefinite detention of individuals like this.

Following his return from Dannemora, relatives noticed a change in his makeup—he was more changeable, seemed nervous, restless, irritable and quick-tempered. He worked fairly steadily for about one month and a half, then resumed his former habits and in addition began pugilistic activities and earned part of his subsistence in this fashion. He resumed, however, his stealing propensities and about three months after his release from Dannemora was arrested for burglary and sentenced to Sing Sing for a period of three years and five months. His conduct at home during this time was unbearable. The father having died, the mother was quite helpless, and finally was obliged to leave home after a threat to kill her if she didn't supply him with money.

Our examination of the boy showed him to be rather undersized and underdeveloped physically, of coarse features. He was extremely infantile in his make-up, rather contentious and pugnacious. He appeared to have no conception whatever concerning the seriousness of his past mode of life, and did not impress one in the least as having benefited to any extent from previous sojourns in correctional institutions. The boy apparently has, up to this time, acquired no well-defined meaning of life, has no insight whatever into his past difficulties, and does not entertain any idea with reference to his future that might justify the assumption that he will improve in conduct. He entered into the examination rather freely, co-operated well, but gave distinct evidence of conscious deception as well as inability to give a correct account of his past life. He was rather boastful in manner when talking of his past exploits, took the entire situation lightly, and seemed to be distinctly pleased with the fact that he was an inmate of the state prison. He insisted that he was innocent of the crime for which he was sentenced, but that he knew who did the crime, but, of course, would not think of telling the police who did it. He was quite well informed on current events and his general information was quite on a par with his educational advantages. He said that the Mississippi River divided the West from the East in this country, that Grant was a general commanding the northern army during the Civil War, that the Spanish-American War was due to the sinking of the Maine, named the Great Lakes, states and capitals without difficulty, and according to an examination by the Terman Revision of the Binet Scale, reached the psychological age of fifteen years and six months, with an intelligence quotient of .96. His vocabulary was about 9,000 words, and he readily performed the Binet Paper Cutting Test, and the Ingenuity Test under the XVIII series. It is extremely interesting to note that his psychometric examination threw so very little light on the inmate's personality, and that the ultimate estimation of his make-up had to depend upon a study of his past career and type of reactions to daily situations. On the other hand, he showed a distinctly emotional deterioration and indifference. Certainly he had no adequate conception of the meaning of his life up to the present and of the difficulty in which he had been, a deterioration which is probably a sequence of the psychotic episode which necessitated his transfer to Dannemora State Hospital.

Can there be any doubt that the correlation between this high percentage of recidivism and mental defect deserves serious attention at the hands of those who administer this problem, and that some effort ought to be made toward a more rational administration of it?

TYPE OF OFFENSE

Crimes which had their impulse in the instinct of acquisitiveness	58
Crimes which had their impulse in the instinct of pugnacity	26
Crimes which had their impulse in the instinct of sex	13
Arson	1
	98

The means employed toward obtaining the goal of acquisitiveness were, in the majority of instances, the usual means of larceny, burglary, etc., but in three cases, compulsory prostitution was resorted to.

Of the twenty-six cases in which the instinct of pugnacity came to light, six terminated in homicide.

Of more special interest is a more detailed classification of the sex offenses. Here we find that rape was represented in five instances; abduction in two and sodomy in six; thus the abnormal sex expression was in the majority.

HEREDITY

The subject of heredity in criminal behavior has been discussed repeatedly by various investigators, and the consensus of opinion still seems to be that there is no reliable evidence to support the view that criminal behavior is to any significant degree hereditary. This, of course, need not be taken as indicative of the hereditary factors that may be involved in the problem of the "defective delinquent." We have considered the question of heredity only so far as our means of obtaining accurate information permit us to do, and what we have to say concerning this should not be taken as a definite criterion of the part heredity plays in this problem. More accurate and painstaking field investigations in each case would be necessary with a sufficiently large number of cases to justify one in drawing any conclusions concerning the question of heredity in the defective delinquent. As far as we were able to determine from our records, hereditary factors of some significance came to light in forty-eight of the ninety-eight cases, as follows:

Alcoholism

Father excessively alcoholic	18
Father periodic drinker	1
Father moderately alcoholic	11
Mother alcoholic	8
	38

Tuberculosis

Father having suffered from tuberculosis	6
Mother having suffered from tuberculosis	2
Brother having suffered from tuberculosis	2
Sister having suffered from tuberculosis	2
Maternal aunts having suffered from tuberculosis	4
	16

Other Significant Hereditary Factors

Mother insane	1
Mother epileptic	1
Father died of apoplexy	3
Sister deaf and dumb	1
Sister defective	2
Sister hystero-epileptic	1
Brother epileptic	1
Brother defective	1
	11

Alcohol and tuberculosis, therefore, seem to have been rather significant hereditary factors in this group of cases.

EARLY PATHOLOGICAL MANIFESTATIONS

Definite pathological behavior manifestations in early childhood and boyhood were brought to light in fifty-two instances, among which might be mentioned the following:

Running away from home
Delayed nocturnal enuresis (in four instances up to ten years of age, and in one instance up to eleven)
Stuttering
Crying out in sleep
Incorrigibility
Sleep walking
Convulsions
Early criminality
Hysterical seizures
Retarded walking and talking

All of these manifestations should have attracted special attention to these individuals, and probably would have, had they been reared in a proper environment. Unfortunately, many of them were brought up under miserable conditions, a fact which must be taken into account in any attempt to define why a given defective becomes antisocial.

In twenty-five instances, definite evidence came to light of association in early life with criminal and antisocial types, and in a number of instances these individuals were deprived early in life of parental supervision, either on account of death or separation of the parents. In eight instances one or both parents died during the subjects' early infancy, and in twenty-three instances, before the subjects had reached the age of fourteen. In three instances the parents separated before this age was reached, and two of them ran away from home before they were fourteen. There can be little doubt that this type of early environment, with its natural consequences, and the lack of parental supervision and guidance had their share in making these individuals what they are. The following case may be illustrative of this point:

N. G., a twenty-year-old Italian-American, who already had a very extensive record of criminality, was admitted to Sing Sing on a sentence of from one to four and one-half years, after having confessed to grand larceny of the second degree.

His grandparents on both sides were primitive Italian peasants; they were born and lived in the neighborhood of Naples. They were simple, illiterate folk, but of good reputation. The paternal grandmother died suddenly of heart disease. The father, aged fifty-four, came to the United States soon after marriage and managed to support himself and family as a bricklayer until about twenty years ago when as a result of a fall he received a severe injury from which it took him several months to recover. Subsequent to this injury, his mind became affected in some way, and since then he has shown a number of mental peculiarities, has declined industrially, and at present earns a meager livelihood as a bootblack. He was deserted by his wife who was at the time pregnant with inmate, soon after he developed mental disorder because of his abuses and cruelty. He has become excessively alcoholic since then. The mother, an illiterate Italian woman, married her husband against her wishes, and conjugal relations were never happy. Soon after her husband was injured and began to show mental symptoms, she went to live as the common-law wife of another Italian. At that time she was pregnant with the inmate, and in addition, had to support two children, by working as a finisher for tailors. She is a well-behaved, industrious woman and, aside from the fact that she has had a number of children by this second man out of wedlock, has shown no antisocial tendencies. The firstborn was found dead when about ten months old, was not quite normal, and always seemed to be in discomfort and crying. The second, a boy, born in New York, attended an industrial school, but never got beyond the fourth grade. He came in conflict with the law early in life, and has never been very successful industrially since. The third, a girl, never reached beyond the fifth grade in school, was not very bright, but tried hard to learn. She is married and living a normal, useful life, although for two years during her married career she had to depend upon public charity to a considerable extent for her support. The fourth was the inmate. The fifth, a half-brother, appears to be normal. The sixth, another half-brother, has always been a troublesome boy. He has been to the Children's Court on a number of occasions, but is industrious at present. Another boy, the son of the inmate's stepfather and a former wife, has led a very abandoned, criminal career, and is believed to have had considerable to do in influencing the inmate's career. In fact, the inmate, constitutionally very suggestible, showed a great desire from earliest boyhood, to emulate this brother's escapades, and later on participated in the criminal activities of this brother.

The inmate was born in New York City on May 16, 1895, probably the fourth in sequence. At the time of his conception, the father had been injured and his mind was affected. He became very brutal in his treatment of the mother during this pregnancy, so that she felt obliged to leave him. Birth, as far as can be ascertained, was normal, but during his infancy, the mother had a hard time supporting herself and two children, and the inmate suffered considerably from want and privation. After she went to live with the common-law husband, home conditions improved somewhat and, although their quarters were very crowded, the home was fairly clean and there seemed to be sufficient simple food. The children were neglected to a certain extent during their early childhood, and the mother states that she had always realized that she never had any marked control over the inmate's behavior. The one brother who has been excessively criminal, was arrested for the first time when the inmate was five years of age, and the mother thinks that the latter was very much impressed at that time with his brother's contact with the police, and seemed to want to emulate him. The home was unattractive, parents illiterate. There were no recreational outlets furnished, and in consequence, they had to be found in the streets, and in an unsupervised manner.

It is difficult to ascertain definitely when the inmate entered school, as his school career was frequently interrupted by sojourns in reformatory institutions, but it appears to have been somewhere between seven and eight years of age. He is remembered by one school teacher as a low-browed, forbidding-looking, unresponsive child; appeared to her to have come to school because he had to; was mischievous, troublesome, and required looking after. He had a very bad temper, lessons were poor; could not apply himself, and never went beyond the fourth grade. He has never been seriously ill and, with the exception of a bullet wound on the scalp which he received when he attempted to escape from one of the juvenile institutions, he never received any serious injuries. His industrial career has been very inefficient, irregular, frequently interrupted by sojourns in reformatories and penal institutions, and there never was an attempt to learn a trade. Several positions which he held lasted only brief periods, and he did not succeed very well at any of these.

His first contact with the law occurred at about the age of eight when, in company with another boy, he was charged with burglary. He was acquitted by the judge on account of his youth and turned over to his parents. Two months later he was again arrested in company with the same boy for stealing several packages of cigarettes, and on October 9, 1903, was committed to the Catholic Protectory, where he remained until May 23, 1905. At that institution, it was recorded that his physical condition was good; that he had no education, no religious instructions and that his habits were wild. On September 18, 1905, he was again arrested in company with Thomas, the half-brother already referred to, for loitering in a doorway. He had been away from home at that time for two days and his parents did not know of his whereabouts. He was recommitted to the Catholic Protectory, where he remained until September, 1906, when he was turned over to his father. At that time he had attended public school intermittently, and had learned to read and write. In May, of the following year, he was arrested in Brooklyn, and sentence was suspended. Two weeks later he was again arrested for attempting to break into a store, and was committed to the House of Refuge. He was paroled from this institution after a sojourn of about two years, and in December, 1910, was again arrested on account of having been implicated in the larceny of a number of watches which were found in his possession. He was returned to the House of Refuge, from which institution he was paroled on May 14, 1911. In the fall of that year he was again arrested, and on January 18, 1912, was sent to the Catholic Protectory under an alias, where, after a month's sojourn, his identity was discovered, and he was returned to the House of Refuge. Subsequent to this, he served a sentence in the New York City Reformatory and in the penitentiary, and on December 4, 1916, was arrested for the present offense and sentenced to from one year to four years and six months. The present offense consisted in stealing a motor car which he took to a neighboring city.

Our examination shows him to be a fairly well-developed and well-nourished boy, aged twenty on admission, January 15, 1917. He is a profoundly defective and infantile individual, very loquacious and talkative, but quite insincere and unreliable in his statements. He constantly put forth a great deal of effort to impress the examiner with his capabilities and blames his difficulties entirely on environmental circumstances. He co-operates well in the examination; is quite cheerful; says he does not worry over anything except the sorrow he has caused his mother. He feels that he should spend his time while in this institution in learning some useful trade. In his ideation he is rather primitive; believes fully in spirits, ghosts and haunted houses, and occasionally hears peculiar noises in his ears, which at times sound like voices. Until about two years ago he had unpleasant visions which disturbed his nights very much.

According to the Stanford Revision of the Binet Scale, he reaches a mentality of about eleven years and four months. In Healy's Construction Puzzle "A," he makes ten erroneous moves against five correct ones. In the Construction Puzzle "B," he makes four erroneous moves. In the Aussage Test, he accepts eight suggestions and resists two. This pathological degree of over-suggestibility has frequently come to light in the detailed account of his conflicts with the law. His reputation at the various institutions where he sojourned is uniformly to the effect that he could not adapt himself to anything that was demanded of him, was very changeable in his make-up, and soon tired of any work that was assigned to him. Superficially, on account of his extreme loquaciousness, he gives the impression of being bright. He has shown in the past, evidences of being very fond of music, and has attempted on a number of occasions to learn to play musical instruments. While one cannot under-estimate the constitutional difficulties of make-up involved in this case, it would be very difficult to overlook the great potentialities for misconduct inherent in the vicious environment and contacts under which this boy grew up.

SCHOOL CAREER

Whatever justification there may have been for the indifference displayed toward the many deviations from average normal behavior, which so many of these individuals manifested in their parental homes, surely the failure to appreciate these indications of a pathological state during their contact with the public school cannot be easily condoned. If our study of the adult offender were to demonstrate nothing beyond the extreme evil inherent in an unintelligent handling of these early manifestations of abnormality of behavior, it will have justified the time and labor expended upon it. Granted that there may be many difficulties in the way of adequately administering this problem while the individuals are still under the entire supervision of unintelligent parents, surely no such difficulty should exist in our school machinery.

Perhaps the very significant fact that out of the ninety-eight native-born defectives 80.6 per cent developed into individuals who are strongly inclined to behave in an antisocial manner, may serve to convince our school authorities that the purpose of education reaches beyond the acquisition of the "three R's."

At any rate, from the biologist's point of view, education should have for its object primarily the fitting of the individual for proper living, and in this respect our school system has singularly failed, as far as these cases are concerned. Not that we believe that any large number of these ninety-eight defectives could have been restored to normality, but we do insist that in a great many instances they gave highly suggestive, if not unmistakable, evidence during their school life of being incapable of proper adjustment under ordinary conditions of life, and that some provision should have been made for placing them in a more appropriate environment. The report of the school teacher in the case just quoted, shows that some consciousness of this grave problem which this boy presented was had at that time. Still, nothing was done that might have shaped his future career differently.

Aside from the fact that nine never reached beyond the third grade, that five never reached beyond the fourth grade, and that twelve never reached beyond the fifth grade, many traits came to light which should have been properly evaluated. Thus, backwardness and inability to learn, which necessitated repetition of classes on one or more occasions, was manifested in thirty-four instances; excessive truancy in twenty-one instances; incorrigibility in five; extremely irregular attendance in eight; inability to get along socially in five; extreme dislike for studies in eleven; one case terminated in expulsion, and a number of them had to be transferred to reformatory institutions directly from school. In four instances school attendance was begun after the age of ten had been reached.

If there has been no opportunity thus far to demonstrate clearly the beneficent results of a rational administration of problems of juvenile maladjustment because a rational approach to this problem has been in vogue only during very recent years, the facts brought out in this study ought to emphasize sufficiently the extreme danger involved in an indifferent approach to such problems.

INDUSTRIAL CAREER

The same inefficiency which has characterized these individuals in their school and social contact, is again reflected in their industrial careers. Out of the ninety-eight cases, eighty-two, or 83.7 per cent were unskilled laborers, while sixteen, or 16.3 per cent were skilled; thirty-nine or 39.8 per cent were employed at the time of arrest, while fifty-six, or 57.1 per cent were unemployed. The industrial careers of practically all of them were very irregular and inefficient as far as earning capacity is concerned.

HABITS OF LIFE

Aside from the rather prominent rôle which antisocial behavior has played in the lives of these individuals, other excesses have no doubt contributed to the general lack of efficiency which characterizes all of them. As far as we were able to determine, excessive alcoholism played a conspicuous part in the lives of thirty-one of them; habituation to various forms of drugs, in eight; excessive gambling, in nine; very promiscuous sex activities, in ten; while perverse sex activity was resorted to in two cases. Twenty-one, or 21.4 per cent, showed by laboratory tests indications of syphilitic infection.

In summing up, we would state, that while we do not subscribe to the idea that laboratory diagnosis alone is sufficiently reliable to justify one to classify an individual as defective, our study seems to corroborate to a remarkable degree the findings of the laboratory. It would lead us entirely too far beyond the scope of this report to enter into a more detailed discussion of the tremendous social problem involved in these ninety-eight cases.

Indeed, the problem is sufficiently staggering to justify any radical departure from present procedure which might promise some degree of prevention of the depredations of these individuals. When we turn to the actual state of affairs, we are confronted with a woeful lack of appreciation of the seriousness of this problem on the part of society. We might recall briefly that of the ninety-eight cases, none of whom possesses an intelligence above that of the average American child of twelve years, seventy-nine, or 80.6 per cent, were not mere prisoners, but individuals more or less definitely habituated to behave in an antisocial manner, and although the most frequent age among them is only about twenty-two, the average number per individual of sentences already experienced is three and a half. And yet, before another year passes, eighteen of these cases will have returned again to society; before another two years pass, thirty-eight additional ones will have returned to society, and before a period of five years elapses, out of ninety-eight, eighty-four, or 85.7 per cent will have been returned again to the community. Is it not pertinent to ask the question: Are we justified in expecting any sort of solution of this problem from our present methods of administering it?

THE MENTALLY DISEASED OR DETERIORATED GROUP

Of the 608 cases studied, seventy-three, or 12 per cent, belong to this group, as follows:

Arteriosclerotic deterioration	3
Morphine deterioration	1
Dementia praecox	36
Manic-depressive psychosis	2
Markedly cyclothemic	1
Paranoid state	3
Organic disease of the central nervous system (syphilitic)	13
Alcoholic deterioration	14
	73

RECIDIVISM

Of the seventy-three cases, forty-six, or 63 per cent, were recidivists, as compared with 64.2 per cent in the unclassified group, and 66.8 per cent of the total 608 cases. It will be seen, therefore, that as far as mental disease is concerned, the problem of habitual recourse to antisocial behavior is not an especially significant one as compared with the defective and the psychopath.

One would expect this to be the case when one keeps in mind that not infrequently the offense is merely an incidental occurrence in the life of a mentally-diseased individual.

TYPE OF OFFENSE

	Number	*Per cent*
Crimes of an acquisitive type	51	69.8
Crimes of a sex type	8	11.0
Crimes of a pugnacity type	14	19.2
	73	100.0

Of the sex cases, three were sentenced for rape; three for bigamy and two for sodomy.

Among the crimes of a pugnacity type, five terminated in homicide.

THE ALCOHOLIC GROUP

The type of offense in the alcoholic was as follows:

Crimes of an acquisitive type	9
Crimes of a pugnacity type	4
Crimes of a sex type (bigamy)	1
	14

Recidivism was represented by 100 per cent of the cases.

Hereditary Factors

As far as alcohol in the antecedents is concerned, nine out of the fourteen cases gave a history of the father's having been excessively addicted to the use of alcohol.

Education

The school careers of these fourteen cases were characterized by much deviation in behavior from that of the average normal child; in two cases this having led to expulsion from school. Excessive truancy was manifested in five cases, and backwardness in two.

Economic Status

Of the fourteen, eight were unskilled laborers, while six were skilled; eight were employed at the time of the commission of the crime, five were unemployed, and one case was not ascertained.

In most instances, alcoholic indulgence has continued throughout life. Six of the fourteen were intoxicated at the time of the commission of the crime; one was partially intoxicated, while one was drinking at the time. It is extremely difficult to estimate the relationship between alcohol and crime. While in many cases no direct relationship between alcoholism and the criminal act can be established, in a not inconsiderable number of cases there is a definite, though indirect, relationship present. Thus, among the defectives, excessive alcoholic indulgence as a more or less fixed habit was present in 31.6 per cent out of ninety-eight cases; while in the psychopaths, 41.7 per cent were addicted to the excessive use of alcohol. In those cases where the relationship is more direct, the rôle that alcohol plays in criminal behavior is indeed very significant, as brief abstracts of the following two cases demonstrate.

Case I This inmate is serving a sentence of five years for burglary. He was born in Brooklyn, New York, in 1870. His father was a chronic alcoholic and the mother was neurotic. The inmate is the second in sequence and spent his infancy and childhood in a tenement house. Nothing unusual is to be noted during this period, except that the parents were perhaps unusually strict with him. He attended parochial school between the ages of seven and sixteen and made normal progress. During this period he was very sociably inclined and liked to mingle freely with the other children. Industrial career progressed normally until about twenty-two years of age when he successfully completed an apprenticeship as stone-cutter. At about this time his father died. His career subsequent to this is characterized by unusually excessive indulgence in alcohol, steady decline in industrial efficiency and persistent recourse to criminal acts as a means of supplying his wants. The first offense occurred at the age of twenty-four, and up to the present when he is forty-six he has served eighteen different sentences, having spent a great portion of this period in penal institutions. Every criminal act had acquisitiveness as its motive, and all were carried out either in a state of intoxication or in close temporal relation to an alcoholic spree. The inmate states that while under the influence of alcohol a sense of freedom from all social restrictions comes over him and he feels free to indulge his acquisitive tendency. An interesting epochal relationship is fixed in his mind in connection with his alcoholic habituation. While he began drinking at nineteen, he was moderate in this habit until twenty-four when, following the death of his father, he became very immoderate, lost, as a result of this, in industrial efficiency, was repeatedly discharged on account of drunkenness and fell victim to an economic dependency which appears to have been back of all his criminal acts. At the age of twenty-nine, there took place a further abandonment and exacerbation of criminal and alcoholic habits, and his first sentence to a state prison took place at thirty. He never married, presumably because he felt he could not support a wife. He is inclined to attribute his addiction to alcohol to what he terms "a too great congeniality with men who made a practice of drinking."

The inmate is prematurely senile, facial expression apathetic, all teeth missing, chest development very poor and breathing shows pathological signs. His hearing is impaired. He shows coarse tremors of tongue, slight Rombergism and exaggerated reflexes. Wassermann reaction of the blood serum is negative. He is deteriorated intellectually and emotionally.

In a long interview concerning his life career, the inmate agrees willingly enough with the examiner, that the best solution of his problem would be to keep him permanently confined at some industrial farm where he could be kept away from the temptations of alcohol and not be subject to the economic dependency which he feels he cannot overcome on account of his inefficiency.

Case II This is a chronic alcoholic, who, aside from a number of minor offenses, is at present serving his seventh sentence in a state prison, as a result of having attempted to commit a burglary while in a state of intoxication.

He is the son of practically illiterate Irish parents. The father, a chronic alcoholic, was a stevedore by occupation. The mother died at forty from pulmonary tuberculosis. A brother, likewise excessively alcoholic, also died from pulmonary tuberculosis.

The inmate was born in New York City, in 1862. His infancy appears to have been normal and his early childhood was spent in very comfortable economic surroundings and under very religious influences. In later life, he states that "religion became distasteful" to him. At the age of nine, when bent upon one of his mischievous escapades, he fell from a roof and sustained a double compound fracture of the right forearm, causing the loss of that limb. He entered parochial school and very soon developed an aversion to discipline and steady application. His persistent truancy and antisocial tendencies finally caused his expulsion after four or five years. A love for idleness and a restless wandering spirit were early characteristics, as were also deceit and rather uncommon indifference to pain of others. Further attempts at education in the public schools were finally given up at the age of thirteen, and his time subsequent to this was spent in hanging about pool rooms with boys and men. At the age of sixteen he attempted to work, but soon tired of this and returned to loafing. At about nineteen he began to indulge in alcoholics, and soon after was committed to the penitentiary for assault. His career following this is characterized by unusually excessive addiction to alcohol, marked economic inefficiency and persistent recourse to criminal acts, mostly from an acquisitive motive. Several arrests took place for assault. Since the age of nineteen he has served four short penitentiary sentences and is at present serving his seventh sentence in a state prison. He never married. At the age of thirty-three, he was infected with syphilis, and claims that during the year prior to his present arrest, he was not free from alcoholic intoxication for a single day.

He is well developed and well nourished; skin shows marked hyperaemia and capillary dilatation; amputation of the right arm at the elbow joint, heart sounds muffled, slight degree of cardiac hypertrophy, arteries sclerotic, hearing poor, coarse tremors of face, tongue and fingers; deep reflexes exaggerated; Wassermann reaction of the blood serum negative. He is considerably deteriorated intellectually and emotionally.

Notwithstanding the serious problems which these individuals present to society, and the prodigious amount of money which has already been expended in administering these cases thus far, they are again serving sentences with definite limitations, and before five years pass, will again have returned to society.

It is true that cases of this type are not frequent in a state prison, although they are to be more commonly found in penitentiaries, where they are committed for minor offenses; but when we stop to consider the absolute fallacy of merely administering the criminal act, instead of the individual back of the act, in cases of this type, we cannot escape the conviction that our courts seem to see in their work an end in itself, rather than a means toward an end.

THE ARTERIOSCLEROTIC DETERIORATIONS

Of the three cases classified under this head, one committed murder, another rape, and the third was convicted of carrying burglar's tools. The first two cases were never before in conflict with the law, and the crime in each instance was the direct result of the impaired judgment and the emotional instability which went with the arteriosclerotic brain changes.

THE DEMENTIA PRAECOX GROUP

Of the 608 cases, thirty-six, or 5.9 per cent, were diagnosed as dementia praecox. Not in every instance was the disease so pronounced as to require treatment in a hospital for the insane, although the diagnosis in each instance was based not only on the changes in personality which go with this disease, but also on the presence of definite sensory disturbances and delusional formations. Six of the thirty-six cases had been previously under treatment on one or more occasions in hospitals for the insane.

Type of Offense

	Number	*Per cent*
Crimes of an acquisitive type	27	75.0
Crimes of a sex type (sodomy 2)	4	11.1
Pugnacity type	5	13.9
	36	100.0

Of the thirty-six cases, twenty-six were recidivists, while ten were first offenders.

A discussion of the precise relationship to crimial behavior of the mental disease known as dementia praecox would involve a detailed presentation and analysis of the case histories, which is being prepared for a separate study. As far as we are able to judge this relationship at present, it appears that a good many of those who have been habitually resorting to crimes of an acquisitive nature, owed their criminality to an incapacity to compete on equal terms with their fellowmen as a result of the mental disorder, and hence resorted to petty crimes as a means of supplying their wants.

The relationship is more pronounced and direct in the sex offender, and in the offender against the person. As compared with the defective and the psychopath, the insane does not present nearly so significant a problem, nor does it mean, as we have already stated, that each case requires treatment in a hospital for the insane. In fact, one of the most beneficial results of the new régime at Sing Sing is just this—that many individuals, who, under the former régime, were frequently guilty of breaches of discipline, owing to their mental disorder, are today able to get along well and keep out of trouble under the more lenient discipline prevailing at this prison.

THE MANIC-DEPRESSIVE GROUP

Of the three cases, including the case of cyclothemia, which are embraced in this group, one had been out of a hospital for the insane only a few days when he was arrested; while another committed the crime during a marked hypomanic state.

THE PARANOID STATES

Of the three cases under this diagnosis, one was guilty of assault; another of rape (a first offender, aged fifty-four), and the third, of extortion. In the case of the assault, the crime was the direct outcome of the mental disorder, while in the case of rape, the arteriosclerotic and senile changes on the basis of which the paranoid condition developed, were directly responsible for the crime.

These three cases which we have diagnosed as paranoid conditions, do not represent, by far, the part that paranoid mental states and attitudes play in criminal behavior. This is especially true in connection with the psychopathic cases, many of whom, in the course of their repeated conflicts with the law, have developed rather marked paranoid attitudes toward organized society—a sort of antisocial grudge—which frequently serves them as a justification for their criminal behavior.

ORGANIC DISEASE OF THE CENTRAL NERVOUS SYSTEM (SYPHILITIC)

In the thirteen cases under this classification, the diagnosis was based on laboratory, as well as clinical, findings. In several instances the condition was very much advanced, and in one instance we were dealing with a paretic.

In nine out of the thirteen cases, or 69.2 per cent, the present constituted the first offense of individuals who never before had shown any tendency to criminal behavior, but who became antisocial as a direct sequence of the pathological condition of the central nervous system. In one instance the crime resulted in manslaughter.

THE MORPHINE DETERIORATION

The one case of morphine deterioration demonstrates very definitely the gradual influence of the habitual ingestion of morphine upon behavior. This man was efficient and capable until, in connection with a protracted attack of empyema, he developed the morphine habit, since which time he has shown a gradual decline in efficiency and earning capacity, and has gradually become recidivistic in crime. In a separate study, the relationship of mental disease and deterioration to crime will be considered in greater detail.

THE PSYCHOPATHIC OR CONSTITUTIONALLY INFERIOR GROUP

Serious as is the problem which the defective delinquent presents to society, it is by no means nearly so serious as is the problem of the psychopath with antisocial tendencies. In dealing with the defective, we at least have a number of rather dependable criteria which enable us to diagnose his condition, and occasionally to get a proper hearing at the hands of those who have to do with the administration of the law. No such dependable criteria are available, as yet, for a diagnosis of psychopathy; at any rate, no well-defined method is at hand, such as would serve to convince the layman that one is dealing with a distinctly abnormal individual.

We shall not enter here into a discussion of the nature of psychopathy, beyond stating that our diagnosis of this condition was based largely upon a study of the life history of the individual, and his mode of reaction to the various environmental influences with which he came in contact. In addition, certain laboratory tests were carried out which aided us in demonstrating the high degree of suggestibility and emotional instability that are so characteristic of the psychopath. As far as the problem of antisocial behavior is concerned, the psychopathic individual certainly deserves much more attention at the hands of society than he has received thus far.

Of the 608 cases, 115, or 18.9 per cent, were diagnosed as psychopathic. Here, again, we shall confine our detailed consideration of this group only to the native born among them, which was represented by ninety-one cases, or, 79.1 per cent of the 115 cases.

RECIDIVISM

Of the ninety-one cases, seventy-nine, or 86.8 per cent, had served one or more previous sentences in penal or reformatory institutions. It will be seen, therefore, that the percentage of recidivism in this group is higher than in any of the other groups, and 20 per cent higher than the recidivism in the entire group of 608 cases studied.

Of the 79 recidivists,

20	are	serving	their	second	sentence
18	"	"	"	third	"
14	"	"	"	fourth	"
11	"	"	"	fifth	"
9	"	"	"	sixth	"
5	"	"	"	seventh	"
1	is	"	his	eighth	"
1	"	"	"	tenth	"

The average number of sentences per man is 3.9 as compared with 3.5 in the defective.

In view of the fact that it is so difficult to convince the layman, and even the medically trained individual, that one is dealing here with decidedly abnormal people, one might pause a little to consider the seriousness of the problem of the psychopath, even from the point of view of his tendency to antisocial behavior alone. We have occasionally found a tendency on the part of those who have the administration of the law in hand to minimize the factor of psychopathology in crime, and when we had occasion to refer to the fact that 59 per cent of the admissions to Sing Sing were classifiable in terms of deviations from normal mentality, we have always felt the necessity of emphasizing, at the same time, the fact that in 67 per cent of the admissions, one was not dealing merely with prisoners, but with individuals who have shown, throughout life, a tendency to behave in a manner contrary to the accepted standards of present-day society.

We have seen from the preceding that the psychopath has contributed in the largest measure to this highly specialized group of habitually antisocial people, and that for the seventy-nine recidivists in this group the average number of sentences per man is 3.9, although the most frequent chronological age in the 608 cases was only twenty-three years.

TYPE OF OFFENSE

	Number	*Per cent*
Crimes of an acquisitive nature	66	72.5
Crimes of a pugnacity nature (3 of these resulted in homicide)	19	20.9
Crimes of a sex nature (1 of these was sodomy)	5	5.5
Arson	1	1.1
	91	100.0

HABITS OF LIFE

Aside from their tendency to behave more or less habitually in an antisocial manner, many of the psychopaths have shown other traits which no doubt tended to influence their behavior.

Thus, excessive indulgence in alcohol, as a habit, was found in thirty-eight cases of the ninety-one, or 41.8 per cent; habituation to the use of narcotic drugs in twenty-one, or 23.1 per cent, as follows: opium in six cases, morphine in one, heroin in nine, and cocaine in five cases. Excessive gambling was found in twenty-four cases of the ninety-one, or 26.4 per cent.

HEREDITARY FACTORS

In twenty-nine out of the ninety-one, the heredity was negative, as far as could be determined. In the remaining 62 cases, or 68.1 per cent, the following hereditary factors came to light:

Father excessively alcoholic	22
Father insane	2
Father tubercular	4
Father died from apoplexy	2
Father suffered from cancer	1
Mother alcoholic	3
Mother hysterical	1
Mother very nervous	1
Mother suffering from fainting spells	1
Mother suffering from brain tumor	1
Mother paralytic	1
Mother suffering from cancer	2
Mother suffering from tuberculosis	2
Mother sexually promiscuous	1
Brother paralytic	1
Brother defective	1
Sister tubercular	3

Sister feebleminded	3
Sister deaf-mute	1
Maternal aunt insane	2
Maternal uncle insane	1

EARLY PATHOLOGICAL MANIFESTATIONS

In only twelve of the ninety-one cases no definite evidence of psychopathic traits in early childhood or boyhood came to light. In the remaining seventy-nine cases, or 86.8 per cent, a host of psychopathic traits were manifested during early life, among which might be mentioned:

Convulsions
Somnambulism
Stuttering
Spells of rage
Running away from home
Crying in sleep
Protracted enuresis
Sex precocity
Nomadism
Sex perversions
Periodic depressions
Dizzy spells
Retarded walking and talking
Hypersensitiveness
Early alcoholic addiction
Early criminality.

SCHOOL CAREER

In twenty-one cases out of the ninety-one, the school career appears to have been normal. In the remaining seventy cases, or 76.9 per cent, marked deviations from the behavior of the average child were manifested. Thus, excessive truancy was found in fifty-five cases, and backwardness which led to repetition of grades on one or more occasions, in twenty-two cases. Lack of interest, dislike of discipline, revolt against school authority, general trouble making, extreme mischievousness are further characteristics manifested during school life. Some of them were expelled from school and others were transferred directly to reformatory institutions.

Here, too, it may not be amiss to refer to the lack of interest displayed by the school authorities in early evidences of deviations from average normal behavior. It is true that in the case of the psychopath, a diagnosis is not so easily made as in the case of the intellectually defective, but it is just for this reason that we must avoid falling into the error of trying to define all deviations from normal behavior by psychometric methods. It is a well-known fact that although the psychopath may also show evidences of retarded intellectual development, he need not do so, and actually does not in many cases, and to diagnose as normal any one of these psychopaths whom we have been considering, because he reaches the required intellectual standard according to psychometric methods, is not only unscientific, but dangerously misleading. There is great need for a more dependable definition of the psychopathic individual, or constitutionally inferior, especially of those with inherent antisocial tendencies. No phase of research work in a penal institution would be more productive of results than the study of the psychopath.

SEX HABITS

In contemplating the life histories of these ninety-one individuals, one is struck very forcibly with the unusual lack of all conception of sex morality. Thus in eight instances, repeated recourse to perverse sex activities was manifested in individuals who did not seem to be biologically sexually inverted, since their promiscuity in sex activities was as extensive among the opposite sex as among their own sex, and the perversions were in several instances polymorphous in type. Markedly promiscuous sex activity was manifested in thirty-one instances. In fourteen out of the ninety-one cases, laboratory evidence of syphilitic infection was found.

THE INDUSTRIAL CAREER

Of these cases sixty-one were unskilled laborers, and in thirty instances, three or more changes in type of occupation were made during the industrial career. At the time of arrest thirty-six were unemployed. The industrial career in practically all of them was extremely irregular and inefficient, without goal or object of any kind in view.

In contemplating the foregoing facts, one cannot escape the conviction that the psychopath with antisocial tendencies is by far the most dangerous individual with whom we have to deal, and one would expect that society would exercise an unusual degree of effort in its attempt to solve the problem which he presents. We find, however, that here, too, there seems to be a total lack of appreciation of the gravity of the situation. Thus, before another year elapses, twenty-three of these cases will have returned to society; before two years pass, twenty-one more will leave the prison, and before five years pass, thirty-one additional cases will find their way back to their former haunts. In other words, before five years elapse, seventy-five out of the ninety-one cases, or 82.4 per cent, will have been returned to the community and will be at the point at which they were prior to their last conviction.

THE FOREIGN GROUP

Of the 608 cases studied out of 683 consecutive admissions to Sing Sing, between August 1, 1916, and April 30, 1917, 213, or 35.03 per cent, were foreign born, as follows:

	Number	*Per cent*
Italy (Practically all came from Southern Italy)	68	31.9
Russia (40 of whom were Russian Hebrews)	58	27.2
Germany	25	11.7
Austria-Hungary	18	8.4
Ireland	6	2.8
British West Indies	5	2.3
Greece	4	1.9
Canada	4	1.9
Roumania	4	1.9
England	3	1.4
Cuba	2	0.9
France	2	0.9
Denmark	2	0.9
Holland	2	0.9
Mexico	1	0.5
Porto Rico	1	0.5
Brazil	1	0.5
Scotland	1	0.5
Turkey	1	0.5
Switzerland	1	0.5
Norway	1	0.5
Sweden	1	0.5
China	1	0.5
Finland	1	0.5
	213	100.0

It will be seen that Italy and Russia furnish by far the most significant share of the foreign population in these 213 cases. At the same time, it must not be lost sight of that the Italians and Russians constitute unquestionably the bulk of the foreign population in the Metropolitan district. A detailed consideration of the facts elicited in connection with each group will be given later. For the present, however, two factors which may be applied generally to the entire group of foreigners might be mentioned.

AGE AT COMMITMENT

The age at commitment ranges between sixteen and sixty-four, the most common age being twenty-seven. The most frequent age in 1,000 consecutive admissions, irrespective of race, was twenty-four. Compared with 395 native-born inmates in this series of 608 cases, we find the ages here ranging between sixteen and sixty-eight, the most frequent age being twenty-two. It would appear, therefore, that the average foreigner shows a tendency to get into a state prison at a later age than does the average native born, notwithstanding the fact that many of these foreigners came to the United States at a rather early age, the most frequent age of arrival in the 213 cases being fifteen.

RECIDIVISM

Of more interest, is the comparison of the frequency of recidivism between the foreign born and the native born. Here we find that whereas the percentage of recidivism among the native born of these 608 cases was 75.9 per cent, in the foreign born it was only 49.8 per cent, or 106 out of 213 cases. Intimate study of the individual foreign-born inmate bears out the contention that in a far greater number of instances one is dealing with the so-called "accidental offender," adverse social and economic conditions frequently adding to the chances of committing an offense.

It might not be out of place to mention the further significant fact that, whereas, the foreign population among the 608 cases constitutes but 35.03 per cent of the total, according to an estimate made for us by the Federal Census Bureau, the number of foreign-born male adults over sixteen years of age (1,223,311) in the area from which Sing Sing receives its prisoners is greater than is the native population of male adults of the same age (1,119,776).

THE ITALIAN GROUP

Practically all of the sixty-eight cases belonging to this group came from Southern Italy, and in forty-three, or 63.2 per cent, a classification in terms of mental anomalies was possible, as follows:

Dementia praecox	1
Organic disease of the central nervous system	2
Psychopathic	7
Defective	33
	43

In estimating the intelligence in all the foreign-born prisoners studied, the factors of education, the length of residence in the United States, the age at arrival, and the language factor involved in the intelligence scale were taken into consideration. The measuring scale employed by us was the Yerkes-Bridges Point Scale, and, in a considerable number of cases, in addition, the Terman Revision of the Binet-Simon Scale and some of the Healy Construction Tests.

Under the "Unclassified" column were placed all cases in whom no evidence of distinct mental defect or deviation could be discovered. Special norms were used in grading these cases, in accordance with the Yerkes-Bridges Scale, that is, they were credited with two years in addition to the score of the actual performance. Of the thirty-three defectives, twenty-one showed a degree of intelligence commensurate with that of the average normal American child of ten years or under; while in no instance did they reach an intelligence beyond that shown by the average normal American child of twelve years of age.

While the proportion of recidivists in the entire group was twenty-two out of sixty-eight, or 32.4 per cent, of the forty-three classified mentally, it was twelve out of forty-three, or 27.9 per cent. This rather high percentage of mental deviations, and particularly the very low level of intelligence manifested by these individuals, emphasizes strongly again the necessity of proper procedure in admitting immigrants to the United States.

The author was stationed at Ellis Island during 1913, and, according to a study made at that time, the average time allowed for the examination of an immigrant was something like nine seconds. Obviously it is out of the question to expect to detect the undesirable immigrant with so brief a period of time allowed for the examination. Be it said to the credit of the United States Public Health Service, that considerable progress in this particular phase of its work has been made in the last few years.

Naturalization and Americanization

It is astounding, indeed, that notwithstanding the fact that the length of sojourn in the United States in these sixty-eight cases varied all of the way from one to thirty-six years, and that forty-four out of the sixty-eight have been in the United States ten years, or over, the degree of acquisition of the English language is very insignificant, so much so that in many instances no examination could be carried out without the aid of an interpreter. This, of course, must be explained by the tendency which the Italians manifest of herding together in certain districts where the Italian language is practically the only medium of expression. At the same time, one cannot escape the conviction that if the various social agencies which come in contact with these groups in time of need or stress had made a greater effort to introduce the English language into these communities, a great deal of social maladjustment might have been prevented.

Although sixty of the sixty-eight Italians were eligible by age and length of sojourn in the United States to citizenship, only four had become naturalized, and only eight had signified their intention of becoming citizens. This finding is quite in line with the transitory nature of the Italians' sojourn in the United States. Many of them, although here for many years, leave their families in Italy with the hope that some day they will have accumulated sufficient funds to return and resume their life in an Italian village. Of the sixty-eight, sixteen were under fourteen years of age at the time of immigrating to the United States, and could have benefited to a considerable extent from our public school system. Seven of the sixty-eight have been here less than five years, and under the provision embodied in the new Immigration Law recently passed by Congress could be deported to Italy.

Education

Of the sixty-eight, twenty-five, or 36.8 per cent, were illiterate. Of the remainder:

2 attended school for only a few months
4 " " " about 1 year
7 " " " " 2 years
4 " " " " 3 "
6 " " " " 4 "
4 " " " " 5 "
2 " " " " 6 "
3 " " " " 7 "
1 " " " " 8 "
3 " " " " 9 "
2 " " " " 10 "
1 " " " " 13 "
2 graduated from common school
1 " " high school
1 no information

The extremely high percentage of illiteracy and the very meagre education of those who did attend school, undoubtedly accounts, in a measure, for the general low level of intelligence as disclosed by the intelligence tests.

It is problematical to just what extent the new Immigration Law will tend to eliminate Italians from our prisons, but it cannot be doubted that the higher standard of education which immigrants from foreign countries like Italy and Russia will have to acquire as a result of this law, will affect materially the volume of crime among the foreign population of our large cities. The process of socialization and acquaintance with American customs and ideals will likewise be more assured as a result of this, and one of the desirable consequences of this socialization will eventually be a reduction in the volume of crime.

Economic Status

A detailed and useful estimation of the economic factor involved in the problem which these sixty-eight Italians present would necessitate a much more thorough and dependable field investigation than we were able to carry out. Such facts, however, as were elicited, are believed to be reliable.

Of the sixty-eight, thirty-four, or 50 per cent, were skilled mechanics; thirty-two, or 47.1 per cent were unskilled laborers, and in two instances, no reliable information could be had.

Fifty-three out of the sixty-eight, or 77.9 per cent, were employed at the time of the commission of the crime, while twelve, or 17.6 per cent, were unemployed when arrested. In three instances, no reliable information could be had.

The correlation between the comparatively low percentage of recidivism in this group, the lowest in all the foreign groups, and the very high percentage of those who were employed at the time of arrest—fifty-three out of sixty-eight, or over 77 per cent—is significant in illustrating the possible factor of unemployment and idleness in crime. In the group which showed the highest amount of recidivism—68 per cent—only 52 per cent were employed, in spite of the fact that in this group only three out of the twenty-five were unskilled.

Type of Offense

Crimes having their impulse in the instinct of pugnacity. These crimes, of course, embrace all offenses against the person, exclusive of sex offenses	31
(In 4 instances the assault led to homicide)	
Crimes having their impulse in the instinct of sex..	9
(1 of these was the raping of own daughter)	
Crimes having their impulse in an abnormal sex instinct (Sodomy).........................	4
Crimes having their impulse in the acquisitive instinct................................	24
	68

It is interesting to note the particular forms which the expression of this latter instinct takes in the Italian, as illustrated by the following:

Selling of cocaine was resorted to in two instances.
Compulsory prostitution resorted to in two instances.
Kidnapping resorted to in two instances.
Extortion resorted to in one instance.
Arson resorted to in one instance.
Dynamiting resorted to in one instance.

The end in all these types of crime was the same, namely, the gain of money.

It will be seen, therefore, that crimes against the person, other than sex, which derived their impulse from the instinct of pugnacity, constituted the largest proportion, namely, 45.6 per cent of all offenses. Another significant fact is that four of the sixty-eight, or 5.9 per cent, were found guilty of sodomy.

To sum up then, of the 608 cases studied, out of 683 admitted to Sing Sing between August 1, 1916, and April 30, 1917, inclusive, sixty-eight, or 11.2 per cent were Italians, most of whom came from Southern Italy. The level of intelligence of these sixty-eight cases was very low; twenty-one, or 30.9 per cent of them, showed an intelligence under ten years of age, and twenty-five, or 36.8 per cent of them, were illiterate. Only four out of the sixty eligible for citizenship became citizens, and only eight had declared their intention of becoming citizens. The economic level of the sixty-eight was only fair; 47.1 per cent were unskilled laborers, and the most frequent crimes to which they resorted were crimes against the person—45.6 per cent. In forty-three cases out of the sixty-eight, or 63.2 per cent, a classification in terms of deviation from average normal mental health was possible.

THE RUSSIAN GROUP

Of the 213 foreigners, fifty-eight, or 27.2 per cent, came from Russia. This constitutes 9.5 per cent of the total 608 studied. Of the fifty-eight Russian immigrants, thirty-one, or 53.4 per cent, were classifiable in terms of anomalous mental states, as follows:

Arteriosclerotic deterioration	1
Organic disease of the central nervous system (Syphilitic)	1
Paranoid state	1
Dementia praecox	1
Psychopathic	6
Intellectually defective	21
	31

Of the defective group, twelve possessed an intelligence equivalent to that of the average normal American child of ten years or under, while in no instance did the degree of intelligence reach beyond that of the average American child of twelve.

Compared with the Italian group, this group shows a considerably lower percentage of mentally classifiable cases—53.4 per cent as against 63.2 per cent, while, at the same time, it shows almost double the percentage of recidivism.

The percentage of recidivism in this group was 60.3 per cent as compared with only 49.8 per cent in the entire group of immigrants, and 32.4 per cent in the Italians. This decidedly high percentage of recidivism in this group, as compared with the Italian group, becomes still further illuminated when we consider the type of offenses manifested. One can hardly escape the conviction that there seems to be a very decided tendency for certain races to show a definite selectiveness in their expression of antisocial tendencies. It would be far beyond the scope of this report to enter into a detailed discussion of the possible factors of constitutional make-up and environment that may influence this selectiveness. We have seen that with the Italians, crimes which have their impulse in the instinct of pugnacity, were the most frequent ones. It would not be fair to attribute this solely to the well-known nervous instability and impulsiveness which is common among the Italians, especially those from Southern Italy. It would seem that the low grade of intelligence and extremely limited degree of education deprive these people of many outlets for the solution of their grievances, which the educated and more intelligent person may have at his disposal, and, in consequence, they show a tendency to settle their difficulties in a crude and most natural way, namely, physical combat. As we shall see below, the most frequent crime in the Russian group, which, by the way, contains 68.9 per cent of Hebrews (of the entire group), were crimes which had their impulse in the instinct of acquisitiveness. It is well known that the conditions under which the Russian Hebrews are obliged to live in Russia, make their struggle for existence an extremely keen one. Is it not likely that the prevalence of this type of crime among them may be looked upon in part as a compensatory expression of an instinct which had found but a meager outlet heretofore?

Naturalization and Americanization

Of the fifty-eight, forty-eight were eligible for citizenship, because of age and length of sojourn in the United States. Of these, ten had become citizens, and six had signified their intention of becoming such.

It will be seen, therefore, that compared with the Italian, the Russian shows a more pronounced tendency to permanency of residence in the United States and to Americanization. Of the fifty-eight, thirty-one were under sixteen years of age at the time of arrival in the United States. The length of sojourn in the United States, at the time of admission to Sing Sing, ranged all of the way from less than one year to thirty-five years. Thirteen of the cases have been here less than five years, and come under the provision of the new Immigration Law for the deportation of alien criminals.

Education

Of the fifty-eight cases, fourteen, or 24.1 per cent, were illiterate, as compared with 36.8 per cent in the Italians. Of those who attended school:

2 could read and write
2 attended school for 1 year
9 " " " 2 years
1 " " " 3 "
7 " " " 4 "
4 " " " 5 "
6 " " " 6 "
3 " " " 7 "
4 " " " 8 "
2 " " " 9 "
1 " " " 10 "
1 " " " 12 "
2 were graduated from public school

Economic Status

Of the fifty-eight, thirty-three were skilled and twenty-one unskilled, and in four instances this point was not ascertained. Twenty-seven were employed at the time of the crime and the same number were unemployed. No information could be had in regard to the employment or unemployment of the remaining four cases.

Again, there seems to be a significant correlation between percentage of recidivism and percentage of unemployment, although 56.8 per cent were skilled mechanics.

Habits

Here, too, one doubts the justifiability of even touching upon this factor, since we feel that our field investigations were not sufficiently thorough or complete, but in seven instances of the fifty-eight, drinking or a state of intoxication at the time of the crime was brought to light. It is significant that in four out of these seven cases, the crimes were either sex or assault. On the other hand, gambling to an unusual degree was manifested as a pernicious habit in ten cases out of the fifty-eight. In nine instances, the offense in these cases had acquisitiveness as its motive. It is not at all unlikely that this pernicious habit leads in some instances to a criminal career of an acquisitive type.

Type of Offense

Crimes having their impulse in the instinct of acquisitiveness	44
Crimes having their impulse in the instinct of pugnacity	11
Crimes having their impulse in the instinct of sex	3
	58

Thus it will be seen that in 75.9 per cent of the cases, the crime had acquisitiveness as its goal, the means employed in most instances being the ordinary crimes of burglary, grand larceny (chiefly in the form of pocket-picking) and robbery. Compulsory prostitution was resorted to in two instances and bigamy was a sex offense in two instances.

To summarize, we find that of the 213 cases of foreigners, 27.2 per cent came from Russia 68.9 per cent of whom were of Jewish stock; the entire group constituting 9.5 per cent of the 608 cases studied. The level of intelligence of these fifty-eight cases was somewhat higher than the intelligence of the Italian group. At the same time, the percentage of recidivism was almost double that exhibited by the Italians. The predominating type of offense was of an acquisitive nature, and gambling was a rather frequent habituation. The tendency to become permanently Americanized and naturalized as citizens was considerably higher than in the Italian group. The percentage of illiteracy was considerably lower, and in 53.4 per cent of the cases, as against 63.2 per cent of the Italians, a classification in terms of deviations from normal mentality was possible. With the increase in the percentage of recidivism, there also was found a more or less corresponding increase in the percentage of unemployment and idleness at the time of arrest.

THE GERMAN GROUP

Of the 213 cases, twenty-five, or 11.7 per cent, were immigrants from Germany, and of the twenty-five Germans, only eight, or thirty-two per cent, were classifiable in terms of deviations from normal mentality, as follows:

Psychopathic	3
Alcoholic deterioration	2
Dementia praecox	1
Organic disease of the central nervous system	1
Defective	1
	8

On the other hand, recidivism was represented by sixty-eight per cent (in seventeen cases out of the twenty-five). It is also significant in this group that notwithstanding the large percentage of recidivism, the education of the group was considerably higher as compared with the rest of the immigrant population.

Were it not for the fact that we are dealing here with only twenty-five cases, and that one does not feel justified in drawing any general conclusions, one might be tempted to doubt the influence of illiteracy and lack of culture as well as of mental deviation upon the volume of crime. This group of twenty-five which shows, on the one hand, the lowest percentage of psychopathologically classifiable cases, yet, on the other hand, represents, perhaps, the group of highest culture, shows at the same time, the highest percentage of recidivism of all the foreigners, namely, sixty-eight per cent. Findings such as these certainly impress one very strongly with the conviction that outside of the factors of mental equipment and mental health, there is something else which may have a determining influence upon the social behavior of an individual. Is it possible that since emigration from Germany has been practically nil in the past decade or so, that only a selected class come to the United States from Germany—a class, perhaps, showing a special tendency to antisocial behavior?

Naturalization and Americanization

Of the eighteen out of the twenty-five who were eligible for citizenship, seven had become naturalized, and one had declared his intention of becoming a citizen. Only two were under sixteen years of age upon arrival here. The length of sojourn of the twenty-five was between two and twenty-eight years; twelve had resided in the United States ten years, or more, and four had resided in the United States less than five years and are deportable under the new Immigration Law.

Education

Of the 25,

1 attended school for 7 years
9 " " " 8 "
1 " " " 10 "
1 " " " 12 "
6 were graduated from public school
7 attended high school.

Economic Status

Of the twenty-five, twenty-one were skilled and four unskilled. Thirteen were employed at the time of the crime, and twelve were unemployed.

Habits

Four of the twenty-five were drinking, or in an intoxicated state at the time of the commission of the crime.

Type of Offense

Crimes having their impulse in the instinct of acquisitiveness	20
Crimes having their impulse in the instinct of pugnacity	4
Crimes having their impulse in the instinct of sex	1
	25

Thus briefly summarized, this group which was represented by 11.7 per cent of the total immigrant population, showed the highest level of education, the lowest percentage of psychopathologically classifiable cases, and, at the same time, the highest percentage of recidivism of all the immigrant groups. Like the Russian group, whose intelligence was considerably higher than that of the Italian group, the German showed a predominant tendency to crimes of an acquisitive nature.

THE AUSTRIAN GROUP

Of the eighteen Austrians, who constituted 3 per cent of the total 608 cases studied, and 8.5 per cent of the 213 immigrants, thirteen, or 72.2 per cent, were classifiable in terms of deviations from normal average mentality as follows:

Dementia praecox	4
Psychopathic	2
Intellectually defective	7
	13

Of the seven defectives, four showed a mental age of under ten years, while none reached beyond the age of twelve. One was a case of imbecility showing a mentality equivalent to that of an average American child of six and five-sixths years. This group showed the highest percentage of mental deviations, and 22.2 per cent of distinct mental disease. Ten out of the eighteen were recidivists, or 55.5 per cent.

Naturalization and Americanization

Of the sixteen cases eligible, by reason of age and length of sojourn in the United States, for citizenship, three were naturalized, and five had declared their intention of becoming citizens. Six were under sixteen years of age upon arrival in the United States. The length of sojourn in the United States was between three and twenty-six years. In five instances the length of sojourn was under five years, and these would have come within the provisions of the new Immigration Law for the deportation of criminals.

Education

Of the 18,

2 were illiterate
2 attended school for 1 year
2 " " " 3 years
4 " " " 4 "
1 " " " 6 "
1 " " " 7 "
3 " " " 8 "
1 was graduated from public school
2 were " " high school.

Economic Status

Of the eighteen, ten were skilled and eight were unskilled. Twelve were employed at the time of the crime and six were unemployed.

Type of Offense

Crimes having their impulse in the instinct of acquisitiveness	13
Crimes having their impulse in the instinct of pugnacity	2
Crimes having their impulse in the instinct of sex	2
Abandonment	1
	18

This group, which only comprises eighteen individuals, is made up of a number of races, and no general conclusions concerning it are justifiable.

THE MISCELLANEOUS GROUP

Of the remaining forty-four cases, no single nationality is represented by a sufficiently large number to justify a separate consideration. Of the forty-four cases, twenty-nine, or 65.9 per cent, were classifiable in terms of deviations from normal mentality, as follows:

Dementia praecox		3
Arteriosclerotic deterioration		1
Organic disease of the central nervous system (Syphilitic)		3
Alcoholic deterioration		
Ireland	2	
Canada	1	
France	1	4
Psychopathic		6
Defective		12
		29

Naturalization and Americanization

Of the thirty-six cases eligible for citizenship, thirteen had become citizens, and two had signified their intention of becoming citizens. Nineteen arrived in the United States under sixteen years of age, and the length of residence was between one and forty-four years. Twenty-six were in the United States ten years or over. Six were in the United States less than five years and are deportable under the new Immigration Law.

Of the forty-four cases, twenty-two, or 50 per cent, were recidivists, and twenty-two, or 50 per cent, were first offenders.

Education

Of the 44,
4, or 9 per cent, were illiterate
1 could read and write
1 attended school less than 1 year
2 " " for 1 "
2 " " " 2 years
4 " " " 3 "
2 " " " 4 "
3 " " " 5 "
2 " " " 6 "
1 " " " 7 "
6 " " " 8 "
5 " " " 9 "
1 " " " 10 "
1 " " " 12 "
1 " " " 13 "
4 were graduated from public school
3 " " high school.

Economic Status

Of the forty-four, twenty-three were skilled and twenty-one unskilled. Twenty-five were employed at the time of the crime and nineteen were unemployed.

Type of Offense

Crimes having their impulse in the instinct of acquisitiveness		26
Crimes having their impulse in the instinct of pugnacity		9
Crimes having their impulse in the instinct of sex:		
Rape	3	
Sodomy	1	
Incest	1	
Abduction	1	
Bigamy	1	7
Abandonment of children		2
		44

In this group, too, owing to the very small number of individuals represented by any given nationality, no general conclusions are justifiable.

GENERAL CONCLUSIONS

The conclusions which one might be justified in drawing from a study of the immigrant population among 608 cases of adult male felons out of 683 admissions to Sing Sing prison between August 1, 1916, and April 30, 1917, inclusive, are as follows:

1. Out of the 608 cases, 213, or 35.03 per cent, were foreign born, and of these 11.01 per cent came from Italy, and 9.5 per cent came from Russia. According to estimates of the Bureau of the Census, of the Department of Commerce, the number of foreign-born adults of over sixteen years of age was 103,535 or 52.2 per cent more than the native born in the counties from which Sing Sing receives its prisoners.

2. Of the 213 cases, 124, or 58.2 per cent, were classifiable in terms of deviation from average normal mentality. This point becomes especially significant when one remembers that the majority of these cases were excludable, according to law, at the time of their arrival in the United States.

In the face of figures of this nature, the statement made by a surgeon of the United States Public Health Service, that during the rush immigration in the year 1913, the average time allowed per immigrant for examination was nine seconds, assumes a sinister quality. The author was stationed during that year at Ellis Island and can fully corroborate the lack of facility and provision for the proper examination of immigrants, especially during the rush season.

3. It would appear from our figures that the immigrant is less likely to commit crime than is the native born. While the foreign born constituted but 35.03 per cent of the total, the foreign population in general is higher than is the native population in the counties from which Sing Sing derives its prisoners. Furthermore, the foreign born showed only 49.8 per cent of recidivists as compared with 75.9 per cent in the natives.

4. The study would indicate that the immigrants showing a higher level of intelligence, likewise manifest a predominant tendency to crimes of an acquisitive nature; while those whose intelligence is on a lower level, are most frequently guilty of crimes against the person, and sex crimes.

5. Under the new Immigration Law, forty-four of the 213 would have been excluded on account of illiteracy, and thirty-five others on account of having come in conflict with the law within five years after arrival in the United States.

6. There seems to be a certain correlation between the degree of recidivism in a given group and the extent of unemployment at the time of the commission of the crime.

7. There does not seem to be any definite correlation between the degree of psychopathologically classifiable cases and the degree of recidivism so far as the immigrant groups are concerned.

8. Only a very slight tendency was manifested to naturalization. Out of the 178 eligible for citizenship, or 83.6 per cent of the entire foreign group, only twenty-seven, or 12.7 per cent of the group, had become naturalized, and twenty-two, or 10.3 per cent, had declared their intention of becoming citizens.

Several tables follow showing the relationship of certain facts among the several immigrant groups. These tables were prepared by Miss Claghorn, of the New York School of Philanthropy.

TYPE OF OFFENDERS

	ITALY		RUSSIA		GERMANY		AUSTRIA HUNGARY		MISCELLANEOUS		TOTAL	
	Number	*Per cent*	*Number*	*Per cent*	*Number*	*Per cent*	*Number*	*Per cent*	*Number*	*Per cent*	*Number*	*Per cent*
First offenders	46	67.6	23	39.7	8	32.0	8	44.4	22	50.0	107	50.2
Recidivists	22	32.4	35	60.3	17	68.0	10	55.6	22	50.0	106	49.8
	68	100.0	58	100.0	25	100.0	18	100.0	44	100.0	213	100.0

COMPARISON BETWEEN FOREIGN AND NATIVE BORN

	FOREIGN		NATIVE		TOTAL	
	Number	*Per cent*	*Number*	*Per cent*	*Number*	*Per cent*
First offenders	107	50.2	95	24.1	202	33.2
Recidivists	106	49.8	300	75.9	406	66.8
	213	100.0	395	100.0	608	100.0

PSYCHOPATHOLOGICAL CLASSIFICATION

	ITALY	RUSSIA	GERMANY	AUSTRIA HUNGARY	MISCELLANEOUS	TOTAL
Dementia praecox	1	1	1	4	3	10
Organic disease of the central nervous system	2	1	1	..	3	7
Psychopathic	7	6	3	2	6	24
Defective	33	21	1	7	12	74
Arteriosclerotic deterioration	..	1	..	..	1	2
Paranoid state	..	1	..	..	..	1
Alcoholic deterioration	..	..	2	..	4	6
Unclassified	25	27	17	5	15	89
	68	58	25	18	44	213

NATURALIZATION AND AMERICANIZATION

	ITALY	RUSSIA	GERMANY	AUSTRIA HUNGARY	MISCELLANEOUS
Years in United States	1 to 36	1 to 35	2 to 28	3 to 26	1 to 44
In United States 10 yrs., or more	44	..	12	..	26
In United States 5 yrs., or less	7	13	4	5	6
Under 16 on arrival	..	31	2	6	19
Under 14 on arrival	16	..	..	..	..
Eligible for citizenship	60	48	18	16	36
Became citizens	4	10	7	3	13
Signified intentions of becoming citizens	8	6	1	5	2

EDUCATION

	ITALY	RUSSIA	GERMANY	AUSTRIA HUNGARY	MISCELLANEOUS	TOTAL
Illiterates	25	14	..	2	4	45
Can read and write	..	2	..	..	1	3
School for only few months	2	..	..	..	1	3
About 1 year	4	2	..	2	2	10
2 years	7	9	..	..	3	19
3 "	4	1	..	2	4	11
4 "	6	7	..	4	2	19
5 "	4	4	..	..	3	11
6 "	2	6	..	1	2	11
7 "	3	3	1	1	1	9
8 "	1	4	9	3	6	23
9 "	3	2	..	..	5	10
10 "	2	1	1	..	1	5
12 "	..	1	1	..	1	3
13 "	1	..	..	..	1	2
Graduate public school	2	2	6	1	4	15
Graduate high school	1	..	7	2	3	13
No information	1	..	..	..	..	1
	68	58	25	18	44	213

ECONOMIC STATUS

	ITALY	RUSSIA	GERMANY	AUSTRIA HUNGARY	MISCELLANEOUS	TOTAL
Skilled mechanics	34	33	21	10	23	121
Unskilled mechanics	32	21	4	8	21	86
No information	2	4	..	..	..	6
Employed at time of crime	53	27	13	12	25	130
Unemployed at time of crime	12	27	12	6	19	76
No information	3	4	..	..	..	7

TYPE OF OFFENSES

	ITALY	RUSSIA	GERMANY	AUSTRIA HUNGARY	MISCELLANEOUS	TOTAL
Pugnacity	31	11	4	2	9	57
Sex	9	3	1	2	7	22
Abnormal sex	4	..	..	..	..	4
Acquisitiveness	24	44	20	13	26	127
Parental abandonment	..	..	..	1	2	3
	68	58	25	18	44	213

THE ACTIVITIES OF THE CLINIC

Soon after the establishment of the clinic, it became apparent that if this new departure in criminology was to justify its existence, the clinic must be more than a diagnostic agency. After all, very little actual benefit and constructive work can be hoped for as a result of the contact of psychiatry with the problems of criminology, unless the facts elicited by the psychiatrist are utilized in connection with whatever endeavor the penal institution puts forth for the reconstruction of the individual prisoner.

The clinic has for its primary aim the delineation, if possible, of the debits in the individual prisoner's make-up which might have been responsible for bringing him into conflict with the law. But it should also aim to outline whatever desirable qualities the individual prisoner may possess, the cultivation of which might aid in keeping him from returning to prison. In other words, in addition to outlining the debits, it should outline the type of credit, the cultivation or development of which will tend to balance the debit side in the individual's make-up. It is obvious, therefore, that in order to succeed in this, the activities of the clinic must be supplemented by a proper background in the penal institution, and in a state like New York, by the entire Prison Department. For this reason we have felt the necessity of outlining a tentative plan for the administration of the prison situation of the state, as far as it relates to the problem of the individual prisoner. It is very gratifying to be able to report that the Governor's Commission on New Prisons has accepted our plan and that the Governor has expressed himself publicly as being in favor of it. The fact that the Superintendent of Prisons has requested a continuation of the clinic, expresses the attitude of the Prison Department toward this plan.

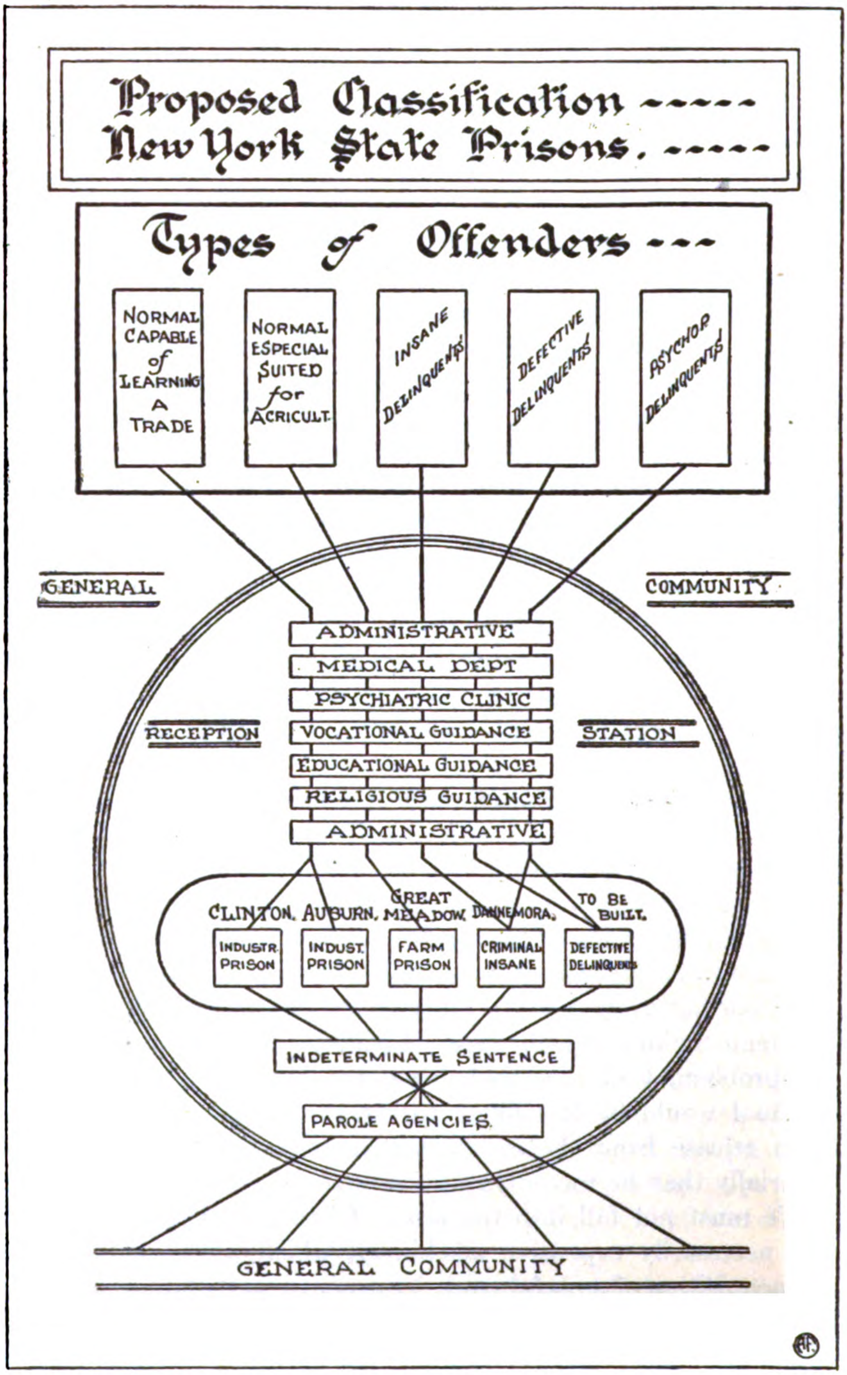
The plan contemplates the erection on the present site of Sing Sing of a new prison which is to serve primarily, if not exclusively, as the classification and research station for the entire prison system of the state. The ultimate relation which this prison is to bear to the other prisons of the state is to be in many ways similar to the relation which the Psychiatric Institute at Ward's Island bears to the state hospitals.

It is intended that every state prisoner should be admitted to this institution first, to be kept under close observation and study, and under intensive vocational training for such period of time as will be necessary to enable the administration to define clearly the problem which he presents. It is estimated that the average offender will probably require a three or four months' sojourn in this institution before such clear definition can be had, and before the kind of training that will promise the best results in a given case may be clearly outlined. Naturally, there will be a certain number of prisoners who will not require nearly so long a sojourn in this institution, and others in whom a clear definition of the problem will necessitate a much longer period of study and observation than three or four months. As far as we are able at present to comprehend the problem of the adult prisoner, it concerns in the main, five more or less well-defined types of individuals, and the state's administration of this problem may well be based upon such tentative, gross classification.

The various penal institutions of the state, other than Sing Sing, with the addition of another unit to take care primarily of the so-called "defective delinquent," will receive the prisoners upon their discharge from the clearing house. The chart on the following page illustrates graphically the scheme to be carried out upon the completion of the new reception prison. Leaving out of consideration the accidental offender, who, before coming to prison was well able to earn his livelihood by honest means, the remainder of the population will divide itself generally into the following five groups:

1. *The normal young adult capable of learning a useful trade*, in whose criminal career the question of economic dependency has played an important rôle, and who, it is believed, would have a greater opportunity to avoid the commission of crime in the future, if, during his sojourn in the institution, he were furnished proper means for acquiring a useful trade. In expressing this hope, one naturally does not mean to imply that this will work out satisfactorily in every instance. Intimate contact, however, with the problem, leads one to believe that the average normal individual would be less likely to revert to criminal behavior if upon release from the institution he were better prepared industrially than he was upon admission.

We must not fall into the error of believing that in creating this necessarily expensive machinery, which will make possible the acquisition of a useful trade by every prisoner falling into this group, we shall simply be keeping in mind the benefit to the individual. It must be obvious to every one that a prisoner with a trade is more useful to the state during his term of imprisonment


Proposed Classification -----
New York State Prisons. -----
Types of Offenders ---
NORMAL CAPABLE of LEARNING A TRADE
NORMAL ESPECIAL SUITED for AGRICULT.
INSANE DELINQUENTS
DEFECTIVE DELINQUENTS
PSYCHOP DELINQUENTS
GENERAL
COMMUNITY
ADMINISTRATIVE
MEDICAL DEPT
PSYCHIATRIC CLINIC
RECEPTION
VOCATIONAL GUIDANCE
STATION
EDUCATIONAL GUIDANCE
RELIGIOUS GUIDANCE
ADMINISTRATIVE
CLINTON.
AUBURN.
GREAT MEADOW.
DANNEMORA.
TO BE BUILT.
INDUSTR. PRISON
INDUST. PRISON
FARM PRISON
CRIMINAL INSANE
DEFECTIVE DELINQUENTS
INDETERMINATE SENTENCE
PAROLE AGENCIES.
GENERAL COMMUNITY

than one without a trade, and that in reducing the chance of recidivism in such individual, the benefit to the state itself is much greater than the benefit to the individual concerned.

2. *The normal prisoner of more advanced age*, who, at the time of coming to prison is beyond his formative period and not very likely to acquire a trade, and who, in most instances, upon his return to the general community, will find his natural level among unskilled laborers. It would entail an unnecessary waste of energy and money to attempt to reconstruct the industrial life of such men, and the prime consideration involved here is the extent to which these prisoners may make themselves useful to the state during the period of their sojourn in the institution. Let me state here, that in the majority of instances, one deals in this group with those who are in prison as first offenders, and who are not very likely to revert to crime upon release, no matter what their experience in prison might have been. Besides, they constitute numerically a relatively small percentage of the inmates. The most frequent age on admission in 1,000 consecutive cases was twenty-one.

These two groups, which constitute numerically between forty and forty-five per cent of the admissions to Sing Sing, are also embraced largely within the group of first offenders. Thus, while not presenting the most serious or difficult problem in the field of criminology, it is imperative that the state should do everything in its power to prevent a relapse in these cases which offer such good possibility of becoming law-abiding citizens in the future. The matter becomes somewhat more complicated with the remaining three groups, which represent roughly between fifty-five and sixty per cent of the admissions, and which are largely embraced within the group of recidivists. Here we have:

3. *The Insane Delinquent.* The prisoners belonging to this group are either actively insane at the time of admission to the penal institution so that they require immediate transfer to a hospital for the insane, or, while showing unmistakable evidence of mental disease, are still capable of conducting themselves in such manner as not to make it imperative that they be transferred to such hospital. They represent people, who, in a considerable number of instances, had had a mental breakdown and were discharged from hospitals for the insane as socially recovered, that is to say, patients in whom the active disease had become quiescent and who were capable of such degree of adjustment as to enable

them to get along on the outside under very simple conditions. Some of these men will actually require a transfer to a hospital later on, but until such time, they could be made quite productive for the state during their stay in the prison. The problem that these prisoners present assumes greater gravity if, as a result of their mental disease, they incline toward criminal behavior. In that case, even though the insane prisoner is capable of adjusting himself adequately to the requirements of the penal institution, it is questionable whether he should ever be returned to the community upon the expiration of his sentence, and in some instances, the problem would be best solved by a permanent confinement in a hospital for the insane. We have in mind particularly one individual who, for years, has been getting along well in Sing Sing, although harboring very decided delusional ideas with reference to a number of people on the outside. Close inquiry into his mental condition convinced us that the man was very likely to commit a serious crime upon his release from the institution, because, as a result of his delusional ideas, he harbored a very grave grievance against a number of people, including his seventeen-year-old daughter. It was for this reason that it was considered advisable to transfer the man to a hospital for the insane, and not because his mental condition interfered with his capacities to adjust himself to the requirements of the penal institution.

4. *The Defective Delinquent.* The prisoners who come within this group constitute individuals suffering from various degrees of arrested mental development. They have shown a tendency to commit crime repeatedly as a result of their defective general intelligence, and the ordinary methods of procedure which are available, even in the best conducted penal institutions, are not likely to produce the degree of reconstruction of personality which would assure normal social behavior upon their release to the community. A considerable number of these individuals will require for a rational solution of the problem which they present permanent segregation in an institution for defective delinquents. In such institution, the majority of these inmates could be made self-supporting through some simple work, and could be made to lead satisfactory lives without being exposed to the vicissitudes of a complex social order and without exposing society to the menace which is inherent in a defective inclined to behave in an antisocial manner. The percentage of defectives among the recidivists is very large indeed, and one feels that if the problem of mental de-

ficiency were handled more intelligently, the amount of recidivism would be reduced considerably.

5. *The Psychopathic Delinquent.* These prisoners are burdened with a mentality which, while not placing them within the well recognized categories of mental disease, brings them decidedly outside the pale of normal human beings. The psychopath contributes very largely to the ranks of the recidivists and in many respects constitutes a greater menace to society than does either the insane or defective delinquent. But while, in many instances, not much hope may be entertained of bringing about a decided reconstruction in the personality of the psychopath, many others are capable of being readjusted, at least to the extent of leading a useful and normal existence under proper circumstances. It is this group which will require the most intensive individual attention in prison if the problem that they present to society is to be solved with any degree of success.

The clearing house, after having defined and classified the inmates which it receives from the general community, will distribute them to the various institutions of the state, in the following manner:

A. The normal, young adults, capable of learning a trade, after having been well started in acquiring the trade for which they are best suited as determined by a scientific inquiry into their capabilities, will be transferred to either one of the two industrial prisons of the state, located at Dannemora and Auburn.

B. The older, normal prisoners who will be found incapable of learning a trade, will be transferred to the agricultural prison at Great Meadows, where they can make themselves most useful to the state in some form of agricultural occupation. They also will be used in the housekeeping of the various institutions.

C. The insane delinquents who require treatment of a more or less permanent nature in a hospital for the insane will be transferred to the Dannemora State Hospital (hospital for the criminal insane), while those suffering from transitory, mental disturbances, which may promise recovery under proper treatment, will be treated in a specially constructed psychiatric pavilion at the Reception Prison. This pavilion will also serve as a temporary observation ward for those awaiting transfer to the Dannemora State Hospital.

D. The defective delinquents who, after intensive and careful study, are found to be incapable of reconstruction to a degree which would justify their release into the general community, will be committed for more or less permanent segregation to the institution for defective delinquents, for which procedure, it is hoped, adequate legal provision will be made.

E. The psychopathic delinquent, as we have stated, will require the greatest amount of attention. Some psychopaths break down completely under the stress of imprisonment and require treatment in a hospital for the insane; others will eventually have to be segregated more or less permanently in the institution for the defective delinquent. But so radical a procedure as permanent segregation should never be resorted to until a competent Board of Inquiry has so recommended as a result of thorough, scientific investigation into the problem involved.

Such, briefly, is the tentative plan for the reorganization of procedure in the Prison System of the State of New York. It is radical in its departure only to the extent that it intends to be governed in its administration of the problem of crime by scientific facts instead of blind tradition, and in that it earnestly intends to apply all of its resources toward an attainment of that ultimate goal which all of us desire—the readjustment of that badly adjusted human being, the criminal.

There can be very little doubt that better results will be effected in the administration of the problem of crime through the type of administration outlined. The chances, however, for actual constructive work would be still better were crime solely the result of individual, constitutional make-up. Unfortunately, social factors contribute in not an inconsiderable degree to this problem, and the best approach toward the minimizing of these undesirable social factors still seems to be through education and suitable propaganda. It is but natural that an institution like a psychiatric clinic in connection with a prison should be one of the most potent agencies in this regard because of its unique opportunity of acquiring reliable information.

The clinic, since its establishment, has been active to a considerable degree along these lines. Thus far, scientific papers have been delivered before the Conference of State Institutional Workers, the National Conference of Charities and Corrections, the New York Psychiatric Society, the New York Neurological Society, the New York Psychoanalytic Society, the Massachusetts Society for Mental Hygiene, and the Rhode Island Society for Mental Hygiene. In addition, the following lectures have been delivered: fifteen lectures on Clinical Criminology, at Columbia University; one lecture on Feeblemindedness and Prison Reform, at New York University; six lectures to large groups of members of the New York City Police Department, and one lecture to the Probation Officers of the Municipal Courts of New York City.

As a result of the activities of the clinic, a similar clinic has been established in connection with the Department of Corrections of the City of New York, and at the urgent solicitation of Mr. V. Everit Macy, we have personally organized and have been supervising similar clinical activities in connection with the Department of Charities and Corrections of Westchester County.

The clinic at Sing Sing has been visited by many people from all parts of the United States interested in similar work and we have been consulted by correspondence from many sources.

A further means of useful propaganda was seen in the examination of all cases appearing before the Parole Board, and in the rendition of reports of our findings to this Board. In addition to our routine work, there were examined up to April 30, 1917, 168 parole cases.

As a therapeutic agency the Clinic has further made itself useful in cases of individual difficulties of adjustment among the prisoners, and 51 cases of this nature were examined and administered.

In conclusion, we wish to express the hope that the State administration will see clearly the necessity of some such approach to its problem of crime as we have outlined above, if better results are to be achieved than have been heretofore.

NOTES AND COMMENTS

Special classes in the public schools for mental defectives have been established in 23 cities and towns of Massachusetts. There are now about 3,000 children enrolled in these classes, and it is estimated that at east 4,000 more need similar training.

In compliance with a resolution adopted recently by the Morris County Medical Society that, "if possible, at least three hospitals in the county establish a clinic for the treatment of syphilis or specific blood disorders," the Board of Managers of the New Jersey State Hospital at Morris Plains at its recent annual meeting authorized the establishment of such clinic at this hospital. Through the liberality of high-grade drug concerns, the necessary drugs are to be provided without expense to the hospital or state.

A Bureau of Venereal Diseases, as a part of the California State Board of Health, has recently been established. All city, county and other local health officers are appointed inspectors of the board and are directed to use all available means to ascertain the existence of, and to investigate all suspected cases of, and ascertain sources of, such infections. They are authorized to make examination of all persons suspected of being in the infectious stages, and to isolate them when it seems necessary for public protection, such isolation not to terminate until the case has become non-infectious or until permission has been given by the board or its secretary. These officers are urged also to suppress prostitution. They are requested to keep all records pertaining to inspections and examinations in files not open to the public, and to make every reasonable effort to keep secret the identity of the persons examined as far as may be consistent with the protection of public health.

Two new ward buildings are to be erected at the Northern Hospital for the Insane located at Sedro Wooley, Washington, at a cost of $98,000, and the State Custodial School, at Medical Lake, is to have an annex constructed at a cost of $80,000.

The State Commission for the Feebleminded, Delaware, created by legislative enactment in 1917, has two sites under consideration for the new Delaware school for the feebleminded. One is in New Castle County and the other in Sussex. The soil of both these sites is being examined as to adaptability for agricultural and other purposes. It is probable that definite action will be taken soon toward purchasing one of these two properties.

At the Taunton State Hospital (Massachusetts), a society has been formed consisting of the superintendent, staff, nurses and employees, each of whom has pledged to contribute a small sum monthly for the duration of the war. These funds are used in buying material to be made by both men and women patients into supplies for the soldiers and garments for destitute Belgians. The work is under supervision of the ward nurses.

A clinic for the examination of children suspected of being mentally deficient is being conducted in New Bedford, Massachusetts, through the co-operation of the school department and Dr. Walter E. Fernald, Superintendent of the Massachusetts School for the Feebleminded. Last year a clinic was conducted in New Bedford under the auspices of the state institutional authorities. With the co-operation of the local school authorities, the clinic will not have to depend upon outside agencies for the cases, as formerly. The first clinic this year was held November 3. Subsequent sessions will be held once a month on a Saturday.

Although the Texas Colony for the Feebleminded is not yet completed, there are now 41 women patients in the institution. When completed, the capacity of the institution will be 140 patients—two wards of 70 beds each, one ward for male and one for female patients. The ward for women, which is almost completed, is now being used by those in the institution.

The Spring Grove State Hospital, Catonsville, Maryland, will request $100,000 from the 1918 legislature with which to equip its new psychopathic building.

Plans have been made by the department of health of St. Louis, Missouri, to establish free syphilis clinics under municipal control. A campaign of education will be conducted emphasizing the importance of these clinics and the benefits to be derived from early treatment of the disease.

There are 369 children in the special classes for mental defectives in Newark, New Jersey.

Rochester, New York, has a unique method of keeping patients having venereal diseases under dispensary treatment. The plan calls for regular visits at the clinic maintained by the health department. When a patient leaves the clinic he is told when he is expected again, and a written notice is sent to him, in case he does not appear, stating that unless he does so he will be visited by a police officer. In case he continues to absent himself he is taken to a local police court and committed to the care of the health officers.

A board of managers has been appointed by the governor for the Hospital for Negro Insane authorized by an act passed by the 1917 session of the legislature of Texas.

The Ontario Board of Health will be requested by the health department of Toronto to have all persons with venereal diseases placed under quarantine. Legislation to provide for the examination of any one suspected of being infected will also be urged.

Ten new buildings, each to accommodate 30 patients, are being added to St. Elizabeths Hospital, the government hospital for the insane, at Washington, D. C.

A psychopathic section has been opened at the Military Hospital, Orpington, England.

Wichita Falls has been selected as the site for the new hospital for the insane—the Northwest Texas Insane Asylum, for which the 1917 legislature appropriated $400,000. Work will begin next spring and it is hoped that the institution will be ready for occupancy in January, 1919. Wichita Falls offered a free site of 500 acres and water supply for the institution.

A site will be selected soon for the new hospital for the insane authorized by the Pennsylvania legislature, in 1917, to be known as the Eastern Hospital for the Insane. The Western Hospital for the Insane, authorized in 1915 and for which the 1917 session made an appropriation, will be located not far from Irwin.

Chapter 90 (1917) appropriated $85,000 for the construction and equipment of a building for the violent and criminal insane at the Oklahoma Hospital for the Insane, at Norman. This institution also received an appropriation of $20,000 for the purchase of 340 acres of land, and $51,682.75 for a central power plant.

The East Oklahoma Hospital for the Insane, at Vinita, received an appropriation from the 1917 legislature of $6,400 for the purchase of 160 acres of land, and $29,597 for the construction of a water system.

The Oklahoma Institution for the Feebleminded received from the last legislature an appropriation of $50,000 for a new cottage and its equipment, half of the amount to be used during the year 1917–1918, and the remainder the following year. A new laundry and water system will also be installed, $25,000 having been authorized for these purposes.

NEW YORK COMMITTEE ON FEEBLEMINDEDNESS

The New York Committee on Feeblemindedness, organized in March, 1916, has recently published its first annual report stating its aims, methods, and an account of its activities.

"It aims to help enlarge the capacity and to increase the usefulness of state institutions; to further the establishment of special classes in the public schools for backward and feebleminded children; to aid in the establishment of a system of guardianship and supervision in the home; and to strive for effective measures and methods looking toward the prevention of feeblemindedness in the future.

"It aims to have segregated those cases which cannot be other than a menace when unprotected in the community and to have them humanely and economically cared for in state institutions; and to have all other cases carefully supervised by responsible persons or agencies. It seeks more extensive provision to train the defectives, especially the children, in the simple manual arts which will make them more useful and happier members of society. It aims to secure a more general public appreciation of the situation created by the presence in the community of so many persons with arrested mental development, and sympathetic co-operation in the attempt to deal with them."

To attain these aims the committee's activities consist in gathering and disseminating information pertaining to the feebleminded, enlisting individual effort and social agencies in effecting such measures as may be brought about privately for the benefit of the feebleminded, and promoting legislation which will secure adequate provision for the care, supervision and training of the feebleminded.

The Committee on Psychological Examination of Recruits, of the American Psychological Association, is composed of Major Robert M. Yerkes, Chairman; W. V. Bingham, Professor of Psychology, Carnegie Institute of Technology, Pittsburgh, Pennsylvania; H. H. Goddard, Director of Research, the Training School, Vineland, New Jersey; T. H. Haines, Clinical Director, Bureau of Juvenile Research, Columbus, Ohio; L. M. Terman, Professor of Education, Leland Stanford University, Palo Alto, California; F. L. Wells, Psychologist, McLean Hospital, Waverley, Massachusetts; and G. M. Whipple, Professor of Education, University of Illinois, Urbana, Illinois.

"Every medical practitioner in Ontario is invited to interest himself in the success of the Hospital for the Insane in the district in which he resides. Every superintendent realizes that the successful results aimed at in the modern treatment of the insane can be more readily secured by enlisting the co-operation and sympathetic support of the medical men who were formerly the physicians to the patients in their homes. The family physician naturally watches with interest the course of the hospital treatment and should consider himself an honorary member of the visiting staff of the hospital to which his patients are sent for treatment." —*Bulletin of the Ontario Hospitals for the Insane.*

MENTAL HYGIENE IN PENNSYLVANIA

The Public Charities Association of Pennsylvania, a body of men and women representative of the entire state, organized in 1912 to aid in securing a system of efficient public charities for the state, recently announced its program for 1918. Among other measures it proposes:

"To assist public and private agencies to organize free mental clinics throughout the state, thus preventing, so far as possible, the increase of mental disorders and facilitating the proper treatment of those suffering from these handicaps.

"To stimulate the opening of special classes for backward and defective children in the public schools, and to co-operate with school authorities in seeking state aid for such classes at the next session of the legislature.

"To co-operate with public authorities in obtaining public support, moral and financial, for necessary improvements in state and local institutions, in order to maintain a high standard of care and treatment of the state's wards and to meet the emergency problems during the war.

"To encourage, by conference and publicity, the useful employment of inmates of public institutions, both to serve their own best interests and to relieve the burden upon the community.

"To conduct a vigorous educational campaign, through pamphlets, newspapers, lectures, exhibits and periodical bulletins, as to the conditions and needs of the insane, feebleminded, prisoners, dependent children, inmates of almshouses, etc., the public policies affecting them and the facilities, methods and needs of institutions caring for them."

The thirtieth dispensary under the auspices of the New York State Hospitals has recently been established for the treatment of mental and nervous diseases.

The governor of Kansas has been requested by the Board of Administration to appoint a committee of professional and business men and women to make an exhaustive study of feeblemindedness in the state and report not later than January 1, 1919.

The study of the feebleminded in Kentucky, conducted by Dr. Thomas H. Haines, formerly of the Boston Psychopathic Hospital and director of the Bureau of Juvenile Research, Columbus, Ohio, has been completed. This study was made for the Kentucky Commission for the Feebleminded which was authorized by legislative enactment in 1916. A report with recommendations has been prepared for the legislature and will soon be ready for general distribution.

The Maine Commission on Provision for the Feebleminded, authorized by the legislature of 1917, has been named by Governor Milliken as follows: Hon. William P. Whitehouse, former Chief Justice of the Supreme Court of Maine, Augusta; Mrs. Marion D. Eaton, Portland, and Rev. David N. Beach, Bangor. A state-wide survey is being conducted by the Commission under the direction of Dr. Guy Fernald, psychiatrist to the Massachusetts Reformatory, Concord. A year will be given to a comprehensive study of the problem of the feebleminded in the state and a report with recommendations will be presented at the next session of the legislature.

CONNECTICUT SOCIETY FOR MENTAL HYGIENE

The tenth annual meeting of this society was held in New Haven, December 12, 1917. Dr. C. Floyd Haviland, Superintendent of the Connecticut Hospital for the Insane, spoke on "Present Day Importance of Mental Hygiene," and Dr. Frankwood E. Williams of New York, on "The Psychiatrist's Part in the War."

INDIANA SOCIETY FOR MENTAL HYGIENE

The Second Annual Conference of the Indiana Society for Mental Hygiene was held at the Claypool Hotel, Indianapolis, December 14, 1917. The morning session was devoted to a discussion of mental health and the war with Will H. Hays, Chairman of the State Council of Defense, presiding. The address was by Dr. Frankwood E. Williams, New York, with discussions by Dr. Charles P. Emerson, Indianapolis, Dr. S. E. Smith, Richmond, Dr. J. W. Milligan, North Madison, Eugene C. Foster, Indianapolis, and Mrs. Hester Alverson Moffett, Elwood. Mental health as a home, school and community problem was discussed in the afternoon and evening sessions. In the afternoon T. F. Fitzgibbon of Columbus presided, and the address was given by Miss Jane Griffiths, Philadelphia. Other speakers of the afternoon were Mrs. Albion Fellows Bacon, Evansville, Mrs. S. C. Stimson, Terre Haute, Dr. Horace Ellis, Indianapolis, O. M. Pittenger, Frankfort, Dr. W. F. Book, Bloomington, and Lee Driver, Winchester. Dr. William L. Bryan, President of Indiana University, presided in the evening, and Dr. Sidney D. Wilgus, representing The National Committee for Mental Hygiene, gave the address. This was followed by a symposium, The Menace of the Mental Defective, To the Neighborhood, To Public Morals, To Public Health, As Seen by the Court, and From the Viewpoint of the State Institution, being presented by Judge W. C. Duncan of Columbus, Mrs. Emerson E. Ballard of Crawfordsville, Rev. A. B. Storms of Indianapolis, Rev. W. K. Ingalls of Jamestown, Dr. Ada E. Schweitzer of Indianapolis, Dr. W. M. McGaughey of Greencastle, Judge E. E. Cloe of Noblesville, Judge F. J. Lahr of Indianapolis, Dr. George S. Bliss of Fort Wayne, Dr. Kenosha Sessions of Indianapolis, and Dr. David C. Peyton of Jeffersonville.

MASSACHUSETTS SOCIETY FOR MENTAL HYGIENE

The Annual Conference of the Massachusetts Society for Mental Hygiene was held at Tremont Temple, Boston, January 9. At the afternoon session, Lieut. John T. MacCurdy, M.O.R.C., of New York, discussed "Nervous and Mental Breakdown from War Strain and Shock;" Dr. F. H. Sexton, Halifax, "What Canada is Doing for Her Soldiers Who Return with Shell Shock;" Dr. Frankwood E. Williams, New York, "What This Country is Doing to Keep from its Armies the Nervously and Mentally Unfit and Adequately to Care for Those Who Become

Disabled by the Shocks and Strains of War." At the evening session, the problem of the defective delinquent was considered. The following papers were read: "The Relation of Mental Defect and Disorders to Delinquency," by Dr. Victor V. Anderson, Medical Director, Medical Service of the Municipal Court, Boston, and Dr. William Healy, Director, Judge Baker Foundation, Boston; "The Defective Delinquent in Court," by Justice Frederick P. Cabot, Juvenile Court, Boston; "The Probation Problems of the Defective Delinquent," by Herbert C. Parsons, Deputy Commissioner of Probation, Boston; "What Shall Be Done with the Defective Delinquent in the Penal Institutions?" by Col. Cyrus B. Adams, Director of Prisons, Boston, and Mrs. Jessie D. Hodder, Superintendent, Reformatory for Women, Sherborn; "What Should Be the Attitude of the Alienist toward the Defective Delinquent?" by Dr. George M. Kline, Director, Commission on Mental Diseases, Boston; "A Practical Program for Dealing with the Defective Delinquent," by Representative B. L. Young, Weston.

Mental diseases and the war, and the work of the Division of Psychiatry and Neurology in the Medical Corps of the United States Army were considered at recent meetings of the Boston Society of Psychiatry and Neurology, Philadelphia Psychiatric Society and the New York Neurological Society.

On the afternoon of January 8, the government films on shell shock were shown before the students of the Harvard Medical School.

The Illinois state hospital service is to have a teacher of occupations to instruct the nurses and attendants in the various state institutions.

Teachers' College, Columbia University is offering a course in occupational therapy. The work will be under the direction of Miss Susan Johnson. Medical problems will be presented by Dr. William L. Russell, Dr. George H. Kirby, Dr. L. Pierce Clark, Dr. Charles I. Lambert, Dr. George S. Amsden, and Dr. Frankwood E. Williams.

Mental Hygiene and the War was the subject discussed recently at the public forum, Portland, Maine.

The Henry B. Favill School of Occupations, a department of the Illinois Society for Mental Hygiene, established in 1914 as a teaching center for the handicapped of the community, has extended its work to include also the training of teachers to educate the mentally and physically defective, and will give special instruction to prepare in advance for the re-education of soldiers and sailors incapacitated for the occupations in which they were previously engaged.

Mrs. Eleanor Clarke Slagle, the head of the school, has outlined and directed courses at the teaching center of the Chicago Chapter of the American Red Cross. The first class was composed of eighteen women each of whom has signed an agreement to give three months' service and they will be sent to Canada for this period.

The school also co-operates with the Chicago School of Civics and Philanthropy which is offering courses of training for the re-education of the physically and mentally disturbed and the handicapped soldier, under the direction of Mrs. Slagle. Lectures upon the medical aspects of occupational therapy will be given by Dr. Wilber E. Post; Dr. H. D. Singer, State Alienist; Dr. Hugh T. Patrick; Dr. C. P. Emerson, Dean of the University of Indiana Medical School; Dr. Herman M. Adler, State Criminologist; Dr. Rachelle Yarros; Dr. F. C. Churchill; Dr. Henry B. Thomas; and others.

MILITARY NEURO-PSYCHIATRY

Major Thomas W. Salmon, on leave of absence as Medical Director of The National Committee for Mental Hygiene, is now in France in charge of the neuro-psychiatric work in the American Expeditionary Force.

The following assignments have recently been made: Lieut. Harold A. Bancroft of Hartford from the New York Neurological Institute to Fort Leavenworth, Kansas; Lieut. Wilson K. Dyer of Kankakee, Illinois, from Camp Lee, Virginia, to Fort McPherson, Georgia; Lieut. Percy B. Battey of Independence, Iowa, and Lieut. Harry A. Durkin of Peoria, Illinois, from St. Elizabeths Hospital, Washington, D. C., to Camp Shelby, Mississippi; Capt. Emil Altman of New York from Camp Sevier, South Carolina, to Camp Greene, North Carolina; Lieut. Smiley Blanton of Madison, Wisconsin, from the New York Neurological Institute to Fort Slocum, New York; Capt. Harry R. Carson of Norfolk, Nebraska, from the State Psychopathic Hospital, Ann Arbor, Michigan, to Camp Pike, Arkansas; Lieut. John C. George of Dayton, Ohio, and Lieut. Ward W. Millias of Rome, New York, from Camp Mills, New York, to Camp Doniphan, Oklahoma; and Lieut. Frank H. Redwood of Richmond, Virginia, from the New York Neurological Institute to Camp Pike, Arkansas.

Capt. Joseph Waldron Moore, formerly assistant physician at the Matteawan (New York) State Hospital, has been assigned to duty at Camp Beauregard, Louisiana.

Capt. Thomas J. Heldt, who has recently been promoted from the rank of Lieutenant, is in charge of the neuro-psychiatric examinations at Camp Doniphan, Oklahoma.

Capt. Walter J. Otis of Waverley, Massachusetts, has been conducting psychiatric examinations at Fort Slocum, New York, which is the recruit depot for the Regular Army, Eastern Department. The work here has been extraordinarily heavy due to the rush of enlistments prior to December 15 when the new draft regulations went into effect.

Major R. W. VanWart of New Orleans, Louisiana, is now on duty under a new assignment at Kelly Field, San Antonio, Texas, conducting the mental and nervous examinations of members of the Aviation Corps, with the assistance of the following officers: Capt. William Edler of St. Louis, Missouri, Capt. John F. W. Meagher of Brooklyn, New York, Capt. Romney M. Ritchey of Elgin, Illinois, Lieut. Nicholas W. Pinto of Kalamazoo, Michigan, Lieut. George E. Hessner of Topeka, Kansas, Lieut. Emory L. Dravo of the State Hospital for the Insane at Warren, Pennsylvania, Lieut. James A. Belyea of Toledo, Ohio, Lieut. John J. Hughes of Mount Vernon, New York, and Lieut. Walter A. Ford of Jacksonville, Illinois.

Capt. Allan D. Finlayson of Warren, Pennsylvania, Capt. Charles Ricksher of Kankakee, Illinois, Lieut. Robert Bogan of New York, Lieut. William J. Fleming of Milwaukee, Lieut. James A. Gould of Westboro, Massachusetts, and Lieut. George A. Hatcher of Nashville, have recently been ordered to Camp Joseph E. Johnston, Jacksonville, Florida.

The neuro-psychiatric unit at Camp Bowie, Texas, is composed of Capt. Otto G. Wiedman of Hartford, Lieut. Samuel W. Hausman of Ogdensburg, New York, Lieut. Howard M. Francisco of Nashville and Lieut. W. Gilford Dickinson of Oneonta, New York, with Major James Ross Moore, previously stationed at Camp Lee, Virginia, in command.

Over 300 neurologists and psychiatrists commissioned in the Medical Officers' Reserve Corps have been detailed to camp duty.

The construction of the neuro-psychiatric wards in National Guard camps and National Army cantonments is rapidly nearing completion. Most of them are now ready for occupancy and the nursing personnel is being assigned according to local needs. The men for this work are being drawn from all ranks of the Army and, following the principle of selective service, are chosen on the basis of training and experience in this particular work, many of those taken having graduated from State Hospitals. Women nurses have also been assigned to these wards and are being supplied by the Army Nurse Corps under direction of the Surgeon-General.

Capt. Thomas J. Orbison of Los Angeles, Lieut. Calvin E. Woolsey of Chillicothe, Missouri, and Lieut. Harold W. Wright of San Francisco are conducting neuro-psychiatric examinations at Camp Kearney, California.

The following officers of the Medical Reserve Corps have been advanced in rank from Captain to Major: George B. Campbell, Richard H. Hutchings, James Ross Moore, Frederick H. Newberry and William Somerville.

Paul V. Anderson, Emil Altman, Wilton F. Beerman, Sanger Brown, II, Richard Eaton, Thomas J. Heldt, Samuel Leopold, Frank Leslie, James F. McFadden, Clifford W. Mack, Walter J. Otis, Arthur S. Pendleton, Horace Phillips, Romney M. Ritchey, Francis M. Shockley and Edward A. Strecker have been promoted from Lieutenant to Captain.

THE WAR'S STIMULUS TO PSYCHIATRY AND PSYCHOLOGY

"Not the least hopeful of the signs of the times is the awakening to a practical interest in military activities. It means on the medical side a recognition of the importance of psychiatry and a furtherance of its establishment in its rightful place among medical branches. Medical authorities, military authorities, psychologists, and the government behind them all, which is seeking 'to co-ordinate and mobilize the scientific resources and forces of the country in the interest alike of national defense and national welfare,' are coming to an appreciation of the overshadowing presence of mental conditions wherever even surgical or organic medical conditions call for treatment or examination.

"In the call to medical service of trained psychiatrists, with their units, as an indispensable feature in this nation's part in the war, there is a note that has been sounding in all the reports from the field of experience of the Allies and of the German armies. Neuro-psychiatry has received an attention never accorded it before. Scientific thought has been preparing for it through the advance in rational interpretative treatment of psychopathological conditions. This has revolutionized the treatment of the so-called insane and has been extending itself to the discovery and improvement or cure of the multitude of borderland cases, which are recognized as worthy also of attention and possible of cure. The war shows that these conditions demand effective, definite, and, as far as possible, rapid action. Psychiatry has an enormous but a specific task."

"The emphasis upon psychotherapy and the psychology of all these disturbances shows most distinctly the progressive trend. Observation and therapeutic experience with these cases recognize the individual mental disposition and the development of symptoms, except perhaps in acute cases resulting from shock which are of temporary duration and emerge from a background of some latent condition of maladaptation or more marked psychopathology. The genetic character of mental disturbance is becoming recognized and applied in the greater care exercised in the examination of recruits and the elimination of those incapable of reacting to the added strain of war. On the other hand the therapeutic value of the strengthening power of these same conditions upon natures whose power of adaptation is thus merely toughened and deepened also bears testimony to reactive ability or disability rather than external circumstances in determining nervous and mental health or disease."—Editorial, *New York Medical Journal*, October 27, 1917.

BOOK REVIEWS

MAN'S UNCONSCIOUS CONFLICT. By Wilfrid Lay. New York: Dodd, Mead & Company, 1917. 316 p.

This work is a complete, up-to-date, simple exposition of the psychology of man's unconscious conflicts. It is so written that the reader of ordinary intelligence may understand it without the aid of a dictionary or a psychologist. So far as the reviewer is aware, there is not an overstatement or misstatement of the principles of psychology in the entire book. However, to the individual suffering from a neurosis, it is of doubtful value to read a book of this type while an analysis is in progress, although this one will probably do less harm than almost any other in this field which has appeared previously. During convalescence from a neurosis, and for a considerable time thereafter, a book of this kind will be of inestimable value. It is by all odds the best book of its kind on dynamic psychology that has come to the notice of the reviewer. The text is set forth impartially and gives to the individual a clearer understanding of the conflicts of human existence, together with practical suggestions for meeting them.

L. PIERCE CLARK.

A MANUAL OF MENDELISM. By James Wilson. London: A. & C. Black, 1916. 152 p.

This little book is a convenient introduction to the modern science of heredity.

The first three chapters deal with Mendel's experiments, his law, and some simple deductions from it. The subsequent chapters deal with special topics. One of these chapters treats of characters due to two or more combined and dissimilar factors (*e. g.*, agouti coloration of rabbits due to three factors). Another chapter deals with "suppressed effects"; that is, the inability of a character to show itself in the absence of some other general factor than that upon which the specific character depends. Thus, all the factors for agouti color of rabbits may be present except a factor (C) that permits pigment to be formed. If this factor be absent the activation of all of the others is suppressed. In chapter six, absence of dominance is treated, well illustrated by the blue Andalusian fowls. When black is crossed with the Andalusian "dirty white," black dominates incompletely; the offspring are blue, and such blues when mated together always yield black, dirty white and blue again. A number of other topics are discussed, including inheritance of quantitative characters—as milk yield in cows—and a brief, final chapter deals with the applications of modern studies in heredity to agriculture.

The book has the advantages of small size, copious diagrams and richness in illustrations drawn from agriculture. Its disadvantages are first, a certain obscurity in style in spots; *e. g.*, such a sentence as: "Too many for one pair of characters and yet not enough for two, three groups suggest two pairs of characters and four groups, two of which are inseparable by the eye" (p. 46) needs to be recast. Second, the author has failed to profit by the recent American work, especially of Morgan and his pupils, which would have clarified his discussion of "coupling." It seems to the reviewer that this little book does not compare with Bateson's great work, with the more popular and briefer book of Punnett or with that of Castle. As a general popular presentation of the science of modern heredity it is much less readable than Walters' *Genetics*. Its subject matter is of special interest to the agriculturalist but the novice will often, it is to be feared, fail to get the desired assistance from it, unless he is very patient and studious.

CHARLES B. DAVENPORT.

THE MASTERY OF NERVOUSNESS. By Robert S. Carroll, M.D. New York: The Macmillan Company, 1917. 315 p.

The keynote of this book of twenty-three chapters is the re-education of self. An account is given of the different phases of nervousness and of some of the obvious conflicts that arise as a result. Titles of some of the chapters are *The Age of Nervousness; The Penalty of Inactivity; Eating for Efficiency; Work and Play; Tangled Thoughts; Ills and Our Wills; Clear Thinking; Moulding the Emotions; The Fulfilment of Self; Our Moral Selves*. The book is a very readable, running account of the many common nervous ills of the human race, although the disquisitions are entirely in the realm of the obvious. The motive running through the text is to suggest to the individual that he employ self-help by directing his mental activities into better channels; but the exact methods showing how to go about it, as well as instruction setting forth the way to meet any particular problem, seem to be wanting. While the book will give the average nervous invalid a better understanding of himself, it will not necessarily enable him to lift himself over the fence by the bootstraps. Specific and definite illustrations showing the manner in which nervous conditions have been fairly met and overcome might well have been included.

L. PIERCE CLARK.

MENTALLY DEFICIENT CHILDREN: THEIR TREATMENT AND TRAINING. By G. E. Shuttleworth and W. A. Potts. 4th ed. Philadelphia: P. Blakiston's Son & Company, 1916. 284 p.

The authors have provided a comprehensive, although necessarily abbreviated, treatise on feeblemindedness as well as epilepsy and the psychoses of childhood and adolescence. The chapter on the psychoses suffers especially from over-abbreviation, and no mention is made of manic-depressive insanity. It is a good move, however, to include a consideration of the psychoses in a book of this character. As our knowledge of the subject of mental deficiency increases, we shall see more of the psychiatric point of view and consideration.

The reviewer has not seen earlier editions of this book, but is nevertheless impressed that there is little new material added except the changes following the passage of the English Mental Deficiency Act. The illustrations are similar to those usually seen in literature upon this subject. The clinical pathology of mental deficiency is hardly more than touched upon, and the endocrinological aspects of the subject are not mentioned. The authors present a sound attitude in their statement that the treatment of mental defect is "medico-pedagogic"; and the book will help to demonstrate that the physician, or more specifically the psychiatrist, is best suited to take charge of the treatment of the feebleminded.

Although the book endeavors to cover the ground for the United States, it is better adapted to English readers. There are many points, however, which make it a valuable addition to any library, and it is especially recommended for the medical student, or the beginner who is anxious to make a rapid survey of the subject.

W. B. CORNELL.

THE PRINCIPLES OF MENTAL HYGIENE. By William A. White, M.D. New York: The Macmillan Company, 1917. 323 p.

In this book White covers an extremely wide field, practically the whole field of human adaptation; his motto might well be *Nihil humani a me alienum puto*. He passes under review the insane, the criminal, the feebleminded, the pauper, the prostitute, the inebriate, the epileptic, the homosexual, the vagrant, the homeless unemployed. He brings within the scope of his discussion such varied subjects as patent medicines, fatigue, divorce, the woman movement, free speech, illegitimacy, social hygiene, dangerous occupations, vocational psychology, fads, wealth, idleness, old age and death. These topics are somewhat bewildering in their variety; they seem to be heterogeneous and to have little in common, but the great merit of this book is that the most diverse problems find their place in a comprehensive whole, the unity of which is due to the point of view of the author. All the above topics are discussed from the point of view of human adaptation, the adaptation of the individual to his complex cultural environment, to the complex and conflicting demands of his own nature. The conditions which lead to success or failure in this adaptation furnish the problems treated in this book.

The failure of adaptation may manifest itself in queer delusional beliefs or in simple symptoms like headache or vomiting; it may be expressed in drunkenness, in prostitution or in economic failure; it may indicate its existence only by the presence of peculiar fads and enthusiasms and character traits. The failure of adjustment may be due chiefly to the difficulties of the individual's own nature, or its cause may reside more definitely in the environment with outworn cultural formulae. The living process of the adaptation of the organism in process of evolution to a cultural environment also in evolution is the keynote of this book.

In parts of the book the author discusses problems of maladaptation which are familiar to all. He takes up the wider social aspects of insanity, crime, pauperism and alcoholism. In using these words one hardly does the author justice, for he vehemently objects to applying a unitary label to extremely heterogeneous conditions. After all, it is time to give up thinking of insanity; it is time to think of a large number of human beings who have failed to adapt themselves to their complex problems, but who have failed in a great variety of ways, and owing to an extremely complex series of causative factors. The author does not fail to refer to such obvious problems as those of suitable provision for the certified insane, or provision for an adequate social apparatus to help patients to a readjustment. He is primarily insistent, however, upon the necessity of keeping in mind the problems of the individual. It can therefore be easily understood that he does not bring forward facile schemes for improvement guaranteed to eliminate from the social organism the maladies which occupy the reformer, but which are liable to persist as long as evolution goes on. Instead of conceiving mental hygiene under the form of a certain cut and dried social apparatus, he conceives it as a body of flexible principles which are derived from the intensive study of human nature.

The author goes deep down to the roots of human conduct, and the more or less familiar discussion of social problems is supplemented by an analysis of human nature which to many will be unfamiliar. He has chosen to employ the language of a new psychology and does not hesitate to bring forward views which many consider extreme and highly speculative. One is afraid that some of this speculative psychology with its unfamiliar terminology and overrefined interpretations may perplex many honest readers, and may seriously antagonize others. It is very important at the present juncture that differences between psychologists should not be overaccentuated, and that the somewhat polemical opening of the twentieth century should give way to a more co-operative and constructive period.

The psychological presentation would have been more in place in a book more technical in its nature, not prepared for so wide an audience. The psychological attitude of the author, however, gives the book an individual note which is very stimulating. Although a few lapses suggest that it has been somewhat hastily prepared, the book is written in a very agreeable style.

C. Macfie Campbell.

The Problem of Personality: A Critical and Constructive Study in the Light of Recent Thought. By Ernest N. Merrington, Ph.D. London: Macmillan & Company, 1916.

No problem has a wider interest than that of human personality. This book attempts to state the problem of Personality "in its relation to the fundamental truths of theology and philosophy." The first part of the book gives a critical exposition of certain views of the Self held by recent British and American philosophers; the second part contains the author's argument for the reality of the Self and his analysis of the value of experience as a concept.

Among the theories of the Self considered in the first part are those of William James, F. H. Bradley, Josiah Royce and G. H. Howison. James is chosen to give the pragmatic definition of consciousness, and his treatment of consciousness as the "Stream of Thought" receives the criticism of the author and is declared wholly unsatisfactory. Bradley's system denies that the Self can make any valid claim to be real. The Self is placed as a concept in the realm of indirect experience with the intellectual constructions. Royce appears as the champion of the system of Absolute Idealism in which the value of the Self has a central place. "Life's meaning makes a Self out of fragmentary and multitudinous elements, which only get their being through relation to the Self, although not fully discovered as yet." The Absolute Self contains in his Life the infinite collection of Selves. Howison maintains Personal Idealism and defines a person as a self-active member of a manifold system of real beings. The universe is the product of the consciousness of this Society of Persons. God is the Supreme Person in this Society. The closing chapter of the expository part of the book, on Later Tendencies in regard to the thought of the Self, is one of its best chapters.

In the second part of the book, the author develops his thesis that the reality of the Self constitutes the reality and trustworthiness of our experience. Although in all the systems of metaphysicians much is made of the concept, Experience, it is nevertheless a vague and ambiguous concept. The Self as Subject in relation to Object is the proper starting point in metaphysics. The Self in this sense becomes the satisfactory criterion of reality. Not, however, the narrow Self of the Rationalists, for the Self has an abundance of life, including the experiences of emotion, activity, imagination, memory, aspiration, and purpose as well as thought.

For such students of philosophy as may care to have in concise form an interpretation of the meaning of the concept, Self, as used by leading English-speaking metaphysicians, this book has value. It will have little interest for others. It has small value for the general reader, for, as the author acknowledges, it is much too technical. It has an inviting title but one that is somewhat misleading, for the book is wholly concerned with the philosophic meaning of the Self. The scientist also, if he expects from the book information in regard to the problem of personality from the field of recent investigation, is certain to be disappointed. The book is destitute of any knowledge of the discoveries of recent science. The scientist will receive from it a vivid impression of the impassable gulf fixed between so philosophic a discussion of the problem of human personality and a book treating of the same problem born within the field of science with the vitality of recent discoveries of the ways of human conduct. There is need of a philosophic statement of the Self written by one familiar with the disclosures of contemporary science. Unhappily in philosophic discussions the reader is frequently reminded of the saying of Lawrence Sterne that most books are made as druggists prepare medicine by pouring from one bottle into another.

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Department of Social Ethics

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MENTAL HYGIENE will aim to bring dependable information to everyone whose interest or whose work brings him into contact with mental problems. Writers of authority will present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public will be republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology will be presented and discussed in as non-technical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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MENTAL HYGIENE

VOL. II APRIL, 1918 No. 2

CONCERNING PRISONERS*

BERNARD GLUECK, M. D.

Director, Psychiatric Clinic, Sing Sing Prison

APPROXIMATELY five hundred thousand persons, according to the latest report of the United States Census Bureau pass through the penal and correctional institutions of this country annually, to resume their lives for better or worse in the community. This stupendous figure throws into impressive relief the fact that the prisoner of today will be the citizen of tomorrow. It renders of the utmost consequence the answer to the question as to how effectively, if at all, our penal machinery operates toward turning out its inmates not merely into freedom but fit for freedom, not merely as citizens but as safe and useful citizens, so far as may be. When, therefore, a study made by us of some six hundred consecutive admissions to Sing Sing Prison during a recent period of nine months reveals the fact that not less than two-thirds, or 66.8 per cent, had already served one or more terms in prisons or reformatories prior to their present confinement, it becomes imperative to inquire into the reasons for such a state of affairs. What accounts for the failure of institutional constraint to prevent relapse into criminal courses on the part of so large a proportion of inmates? The answer traditionally given to this inquiry—that such individuals by the very fact of their recidivism have given proof of being irreformable, either as born or instinctive criminals or as otherwise predestined in their careers—can no longer satisfy the mind of anyone who approaches the situation without bias. A new type of effort is now demanded to locate the causes wherever they may lurk and to place the responsibility impartially where it belongs. This effort must go beyond the external act or crime and seek out the particular determinants in the make-up of the criminal himself, on the one hand, and in his environment both inside and outside of institutions, on the other. It must approach this task free alike from the conventional preconceptions and emotional prejudices that still vitiate much of the discussion and retard practical progress in this field. It must, in short, proceed from the sincere desire to understand human nature as it is and in whatever form of outward behavior it may manifest itself.

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* The author acknowledges great indebtedness to Mr. Paul Wander, Sociologist, Psychiatric clinic, Sing Sing Prison, for his valuable assistance in the preparation of the manuscript.

In this candid spirit we have conducted our investigation, and its results, of which typical selections are offered in these pages, justify the enterprise. Thus, for example, we find that no less than 59 per cent of our 608 cases, in addition to evincing various conduct disorders—the direct cause of their imprisonment—also exhibited some form of nervous or mental abnormality, which in one way or another had conditioned their behavior. Twelve per cent were insane or mentally deteriorated, another 28.1 per cent were intellectually defective, while 18.9 per cent were classified as psychopathic. Among the intellectual defectives we find recidivism in 80.6 per cent, the rate among the psychopaths rising to 86.7 per cent. Nor is it a mere coincidence that the group of sexual offenders, on the whole the most dangerous to social integrity, contained 70 per cent of mentally pathological cases as against a proportion of 58.8 per cent and of 57.2 per cent among the men sentenced for pugnacious and for acquisitive crimes, respectively. The significance of such medical and psychological findings as are epitomized in these figures can not be ignored if one is to understand the social and legal problems presented by an average group of prisoners. If, moreover, we are not to rest content with a mere recording of scientific and statistical data, but desire to see these applied to penal and reformatory practice, it is necessary to obtain a general and intelligent recognition for the constructive possibilities of some such mode of approach to the subject—possibilities for bringing to light a multitude of factors that just so long as they are unrecognized remain a fertile source of failure in understanding and in social control.

On the other hand, the importance of giving more attention to psychological and pathological factors in the make-up of the individual prisoner should not blind us to the large potentiality for good or ill of those agencies of legal control which are collectively charged with the business of reducing the amount of crime in the community and which constitute the prisoner's environment from the moment of his arrest. Owing, no doubt, to our endeavor to see the problem of crime and criminals from all sides and to see it as a whole, we have been impressed with a sense of our own isolation and with the diversity of aims and attitudes held by these constituted public agencies, namely, the police, the prosecution, the defense, lawmakers, judges, juries, jailers, prison and parole officials. Inasmuch as the ultimate and underlying purpose of them all is the fullest safeguarding of the social order with the least incidental violence to the individual, the efficiency of each might fairly be measured by the degree in which it contributes to this end. So far, however, from serving to co-ordinate these specialized endeavors and to humanize and vitalize every segment of the vast machinery of the criminal law, this central purpose seems actually to have been lost from sight. Thus each agency tends to spin about its own center, to pursue its own immediate and sovereign ends, independently of the broader aspects and the deeper implications of the problem of criminal justice, and to restrict the conception of its task from the progressive solution of the problem to its mere routine administration. Thus, too, the kind of justice with which officialdom is too apt to concern itself is of a sort which can be meted out mechanically, impersonally—the backward-looking justice that seeks but to settle a score, to repay an injury in kind, instead of the forward-facing justice that demands a new deal and a square deal for all concerned.

Probably in no other sphere of human endeavor is there evident today a more serious lack of co-ordination of effort than in this of criminal administration. Not that either energy or wealth have been stinted in the struggle against a growing volume of crime. On the contrary, enormous and increasing expenditures of public money and effort are being poured out from year to year along the time-worn channels, yet the tide of criminality has not been successfully checked. The struggle against it is blind instead of being an organized and determined campaign. We are moving in a vicious circle from which we shall not escape until the listless, unimaginative routine handling of prisoners in anonymous masses gives way to a more spirited, experimental approach. An approach of this kind would be made possible by the co-operation of all the agencies and the employment of the already available resources of science in this field. Co-operation, however, presupposes a subordination of means to ends and of personal interests to the general welfare.

Perhaps the chief theoretical obstacle in the way of this humanistic policy is the persistence of a wide-spread superstition in regard to the nature of criminality. The notion of the "born criminal" is even more fatalistic in its finality than the older concept of "original sin," because the victim of the former idea is regarded as irredeemable while from the latter at least escape is possible. But whether it be the theological or the eugenic dogma of predestination that is allowed to paralyze social action relative to reclaiming the criminal, the effect is the same. In either case, he as an individual is despaired of, his past ceases to be of interest, his future ceases to be viewed as a problem containing unknown possibilities, as soon as he has been labeled and put away. It is precisely at this stage in the process that the need for close observation and open-minded study of his behavior, both past and present, becomes critically urgent if his treatment and eventual discharge back into the community is to have any helpful bearing on his future course. For that he shall be discharged has been decreed in advance. If punishment be measured in years, according to the gravity of the offense, instead of being determined by the needs and capacities of the individual offender, it is little better than revenge and apt to prove a boomerang. The paramount interests of social security are jeopardized by assuming that all individuals react alike to a standard mode of treatment and by ignoring the peculiar mental and physical factors in each one's make-up that control his response to the environment. Illustrating this point by our group of sex offenders, we find that many of these have evolved into serious and habitual criminals because society failed to recognize in time and to correct or make allowance for their particular constitutional difficulties. Not that the fact of an offender being feebleminded or epileptic or neurotic constitutes, socially considered, a mitigating circumstance. On the contrary, it aggravates the problem and brings the more clearly into view the inadequacy of an abstract legal procedure for handling what are primarily medical situations. As applied to these serious cases, even the most flexible legal device, such as probation or parole, is incapable, independently, of effecting either reconstruction of the individual or protection for the community. This conclusion is well exemplified by the following case of a feebleminded pervert.

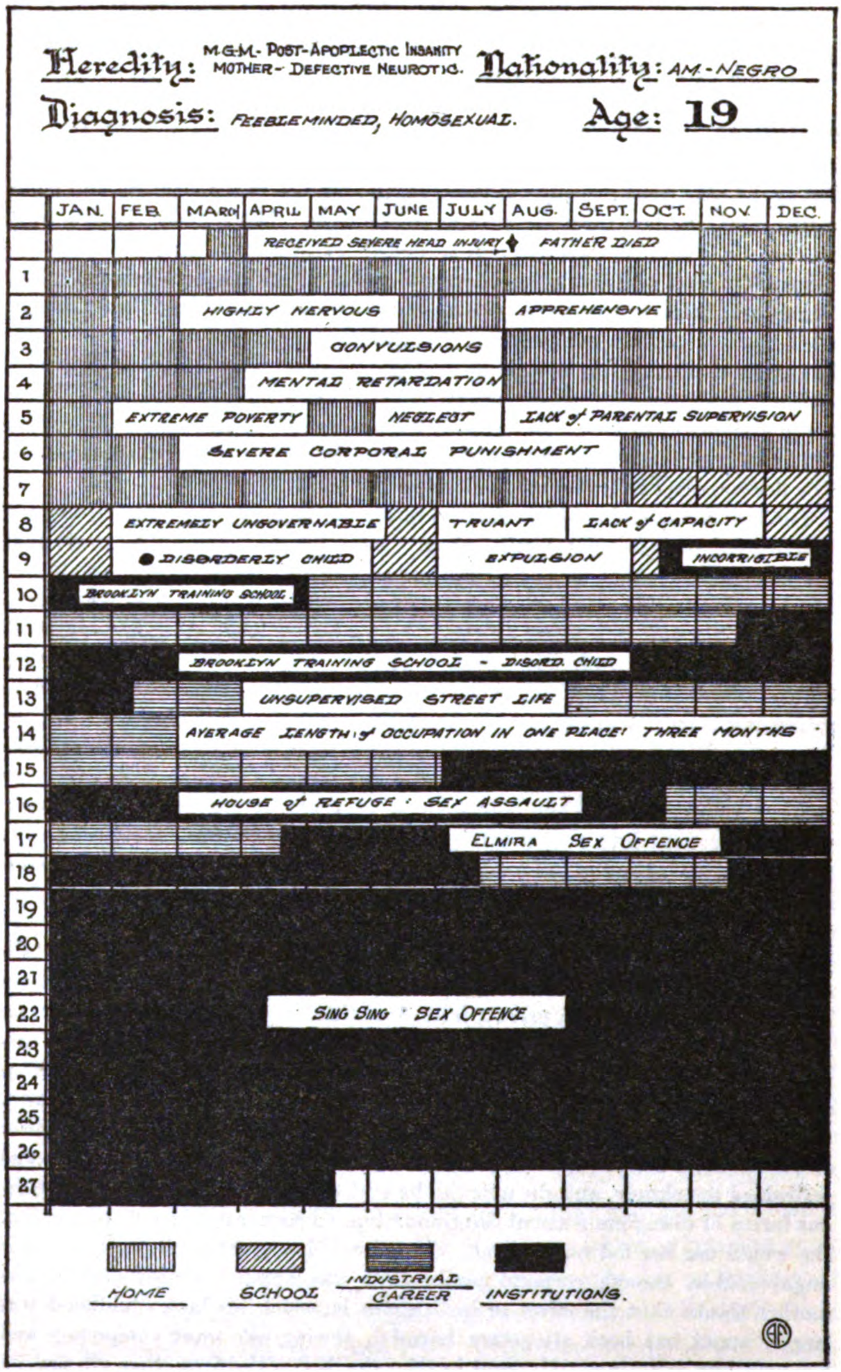
CHART 1

The chart on the next page graphically represents a life career. It is spaced into months and years, the successive periods in the individual's life being shaded in accordance with the key at the bottom of the chart.

This nineteen-year old negro boy, who experienced his first arrest at about the age of nine, is at present serving his fifth sentence in reformatory and penal institutions, the last three for various sex offences. His ancestry is somewhat obscure; it is said that his paternal grandfather was a white man. The maternal grandmother is suffering from dementia following an apoplectic stroke. The father, who is alleged to have been a practicing physician, died of heart disease when the boy was four months old. The mother is described by our field investigator as approximately normal in intelligence, of slight education, suspicious, reticent, attention shifting, extremely nervous, irritable, impulsive and unreliable in statements of fact. In the past she has had frequent attacks of nervous headache with occasional nausea, fainting spells, or momentary disorientation. The doctor called it "nervous prostration."

The inmate is an only child and was unusually large at birth, alleged to have weighed 15½ pounds. His birth and early infancy were uneventful, except that the mother states that when he was four months old she fell with him and injured his head. He was bottle-fed until fourteen months old, and since early childhood has had free access to candy and other sweets. At nine months of age several teeth were already carious from too many sweets, the mother claiming that she had one of them extracted. She says that the child was long in recovering from the shock, became acutely nervous, irritable, and fearful. On the approach of a man he would scream with fright, nearly goingi nto convulsions that suggested chorea. His mental development also appeared to have suffered retardation. When less than a year old (7 months?) while being spanked, he went into a momentary convulsion, all the muscles growing suddenly rigid. This spasm has not recurred in later years. The boy usually lived in fairly respectable neighborhoods, but home conditions were very unfavorable, and from infancy he grew up virtually as an orphan because the mother was obliged to earn her own and the child's support by domestic service. Occasionally he stayed with his mother at the place of service, but most of the time he was boarded out with a private family or with his maternal grandmother, an invalid. The mother was always very stern with him while he was in her custody; she consistently repressed him, allowing him no freedom of expression, and keeping him very quiet and secluded at home. Until the age of seven, when placed in an orphan asylum, he had practically no contact with other children. The mother states that neighbors used to tell her that the boy was restrained too closely, and she now thinks that they were right. She used various forms of discipline without discrimination. Frequently, in a fit of passion, she would use her fist on his head. In spite of her severity, he early became ungovernable, though corporal punishment was applied almost daily. The mother thinks that the effect of institutions in which his later childhood was largely spent has been altogether harmful, cowing him more completely and teaching him evil ways. He slept in the same bed with his mother off and on until eleven years of age and until about the same age would wet his bed.

CHART 1


Heredity: M.G.M.- POST-APOPLECTIC INSANITY
MOTHER - DEFECTIVE NEUROTIC.
Nationality: AM.-NEGRO
Diagnosis: FEEBLEMINDED, HOMOSEXUAL.
Age: 19
JAN.
FEB.
MARCH
APRIL
MAY
JUNE
JULY
AUG.
SEPT.
OCT.
NOV.
DEC.
RECEIVED SEVERE HEAD INJURY
FATHER DIED
1
2
HIGHLY NERVOUS
APPREHENSIVE
3
CONVULSIONS
4
MENTAL RETARDATION
5
EXTREME POVERTY
NEGLECT
LACK of PARENTAL SUPERVISION
6
SEVERE CORPORAL PUNISHMENT
7
8
EXTREMELY UNGOVERNABLE
TRUANT
LACK of CAPACITY
9
● DISORDERLY CHILD
EXPULSION
INCORRIGIBLE
10
BROOKLYN TRAINING SCHOOL
11
12
BROOKLYN TRAINING SCHOOL - DISORD. CHILD
13
UNSUPERVISED STREET LIFE
14
AVERAGE LENGTH of OCCUPATION IN ONE PLACE: THREE MONTHS
15
16
HOUSE of REFUGE : SEX ASSAULT
17
ELMIRA SEX OFFENCE
18
19
20
21
22
SING SING : SEX OFFENCE
23
24
25
26
27
HOME
SCHOOL
INDUSTRIAL CAREER
INSTITUTIONS.

His recreational resources and activities were limited and confined almost entirely to moving pictures, of which he was very fond. He had no friends who called on him at home. His mother often urged him to seek the company of girls of his own age as other boys do, but he shunned them and knows no more of women than a babe does. He was long dependent upon others in dressing. In view of his later sex tendencies and experiences, which have already brought him to reformatory and penal institutions on three occasions, the behavior of this neurotic, ignorant mother towards the inmate during his early life, is highly significant, especially so the practice of sleeping in the same bed until the age of eleven. She, however, blames her boy's downfall to his early contact with life in a reformatory institution and asserts, "They learn all the dirty dirt they know in those institutions."

His schooling was very slight and extremely sporadic between seven and fourteen. Although registered in several public schools during that time, he very rarely attended any, but preferred to spend his days roaming the streets, frequently remaining away from home for days at a time, and refused at all times to study his lessons. In view of present findings of a pronouncedly retarded mental development, his failures were probably due largely to incapacity to carry the work demanded of him. He was in constant conflict with his teachers owing to his unruliness and misconduct in school. On at least one occasion he was expelled from school, in which connection the principal wrote the following letter: "P. is so disorderly that his teacher cannot keep him in the room. She sent him to me, and while I was out of the office, he opened my satchel, took my knife, ten cents, and two pencils. It was only when I threatened to take off his clothes that he gave them up." Notwithstanding his mother's denial, his truancy appears to have been in association with others, who are characterized as "bad companions." Little can be ascertained concerning the character of his frequent disappearances, but evidently they greatly worried his mother, who repeatedly secured his commitment to an institution as ungovernable, disorderly, etc.

His first contact with the law occurred before he was nine years of age, when complaint was made that he was a disorderly child. Disposition was deferred. Several months later he was sent to the Brooklyn Training School on a similar complaint. After about six months he was discharged upon the request of his mother. His behavior did not improve, and in December, 1909, he was again committed to the Brooklyn Disciplinary Training School. It would be of interest to know what, if any, effort was made during either of his sojourns at the disciplinary school to ascertain the underlying whys and wherefores of his incorrigibility. In February, 1911, his mother again made application for his discharge, whereupon the superintendent of that institution wrote to the Society for the Prevention of Cruelty to Children as follows: "I wish to say that this boy has a satisfactory record, has been here a sufficient length of time, and I am satisfied to recommend him to the Committee on Discharge for parole." The boy was accordingly discharged.

It would, doubtless, be out of the question to have expected the boy's ignorant and neurotic mother to appreciate unaided the causes of his difficulty. One might, perhaps, be inclined to view charitably the naive way in which the over-burdened teachers handled his problem, that is, by expelling him from school; but one is constrained to question the good judgment exercised by the parental school authorities in discharging him merely because he had "a satisfactory record and had been there a sufficient length of time." Yet the action of this superintendent was only typical of that of other authorities who subsequently handled the case of this feebleminded boy.

The superintendent of the reformatory where the boy had been sent for having committed an indecent assault upon a three-year-old girl, wrote to the above-mentioned society that the boy was to become eligible for parole on a certain date, and wanted to know whether there were any objections to his release. In reply the society wrote, "We would suggest that before he is paroled it might be well to have him examined by your physician who could determine whether or not he would be likely to commit any further acts of a perverted nature when released. If in the opinion of the physician it is safe to permit the boy at large, and if his record at your institution is such as to be favorable for his parole, the society would offer no objections to the boy's parole." It might have been difficult or impossible to predict with certainty at that time whether or not the boy would ever commit a similar act; but an intimate study of the boy would have brought to light at least the fact of his feeblemindedness, and a prediction based on such information would have indicated continued supervision if not actual custodial care. As a matter of fact, the boy was discharged. When less than six months later he was again arrested for a particularly vicious sex assault upon a boy aged eight, and sentenced to twenty years to the New York State Reformatory at Elmira, his essential problem was not brought nearer to solution. It was the nature of his crime and not of his instinctive and mental make-up that had aroused the moral indignation of the judge who sentenced him. The institutional authorities in their turn, recognizing in him a defective, incapable of being permanently benefited by reformatory treatment, saw fit to release him after fourteen months when he became eligible for parole. The Elmira authorities, in contrast to the agencies which had previously handled the boy more or less blindly, had means of knowing precisely what his future career was likely to be. To quote from their own records: "A coarse type of mulatto; mental status poor; capacity poor; stability poor; moral appreciation poor; susceptibility to training poor." And this is what they had to say concerning his future: "Prognosis: A menace to society; permanent custodial care indicated."

Why, then, did they release him? This query immediately suggests its' obverse: Why, being a reformatory, should they retain him? The facilities for permanent custodial care cannot be provided by an institution designed either for punishment or for reformation.

In view of the doctor's prediction, it is anything but a coincidence that less than four months after his discharge from Elmira, he was again convicted of a perverse sex assault upon a boy aged eleven. At the time of his arrest he admitted to the police that he had used four other boys in a similar fashion. This time his case was administered by a judge who is notoriously sceptical of expert opinion, and who, accepting a plea of sodomy as a first offense, sentenced him to ten years and six months in state prison, this notwithstanding the boy's known dangerously delinquent record.

His industrial career has been extremely inefficient and on a par with his low capabilities. His average length of service in a place was three or four weeks.

We found the boy to be well developed and free from physical disorder. Mentally he was very defective and inaccessible. He comprehended the least complicated questions with considerable difficulty. It was hard to gain his attention and more difficult to hold it for any length of time. His memory was very much confused and unreliable, and affected to a pronounced degree by suggestions from the examiner. He seemed to be considerably taken up with internal distracting thoughts. In the midst of a conversation during which active attention on his part was demanded, he would become preoccupied, lose himself in a sort of dazed state, and when addressed would pull himself together with a start. Orientation for time was uncertain. His emotional state was extremely dull and indifferent. He did not seem to be affected in the least by a discussion of his past criminal career nor by intimate probing into his sex life. His insight into his difficulties was meagre and limited by his restricted intelligence. He claimed to have had his first heterosexual experience at the age of ten with a girl in the neighborhood, but he has always felt a distinct preference for the male sexual object. He insists that he had his first homosexual experience at one of the reformatory institutions, where, he says, this practice was very prevalent among the boys. He has made efforts to abstain from this practice but is incapable in the long run of doing so. He would suddenly get a feeling that he wanted to indulge it, would be uncomfortable, restless, and could not sleep until he did it, when he would experience a marked sense of relief. This urgency apparently was of great potency, since at times he would stop at nothing to gratify it, even threatening to murder the unwilling victim of his assault. He has no conception as to what his future behavior in this respect will be, nor any interest in shaping his future. A psychometric examination gives him a mental age of 11.5 years.

Although sentenced to ten years and six months, his time of release will arrive much sooner than this. But even if he should serve the full term, should he then be released again into the community without further ado? Has there been any adequate effort put forth on the part of society thus far to protect itself from the menace of this boy? Or has there even been any real perception of his problem when the court at his recent trial agreed to treat him as a first offender in the face of the history in the case?

CHART 2

One hundred and seventy-one, or 28 per cent of all the cases studied by us, were found intellectually defective. Considering the ninety-eight natives alone, because better studies were possible among them, we find that seventy-nine, or 80.6 per cent of this group, were repeated offenders who had already undergone an average of 3.5 sentences, and no less than 58.2 per cent had been confined in some juvenile reformatory on one or more occasions. The above estimate of the extent of intellectual deficiency among our prisoners has been very carefully and very conservatively made. But those who are not yet convinced of the significance of this constitutional factor in its bearing on antisocial conduct, need only consider the actual criminal record of this group of prisoners classed as defective to recognize the serious social menace which, under present conditions of short, definite sentences, they constitute. Here is a group of individuals whose most common age is nineteen, 80.6 per cent of whom are repeated offenders with an average record of 3.5 penal sentences, and 58.2 per cent of whom have been juvenile delinquents. Even ignoring the medical definition of this problem, one would assume that in handling a group of persons of such proved criminalistic tendency the state would exercise an unusual degree of care and discrimination. Here is what actually happens: Of the ninety-eight native Americans in this group, 18 will have been returned again to society within one year, 38 additional within two years, and 28 more within five years. In other words, 85.7 per cent of the group will have been released again into the community within five years. Herein lies the danger of ignoring the medical definition of the man back of the act; herein lies the fallacy of trying to fit the sentence to the criminal act instead of to the criminal back of the act.

CHART 2

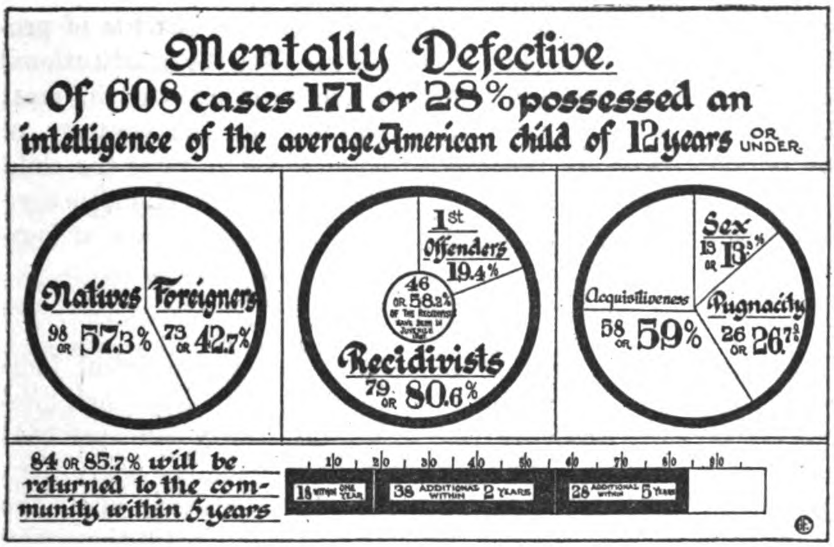


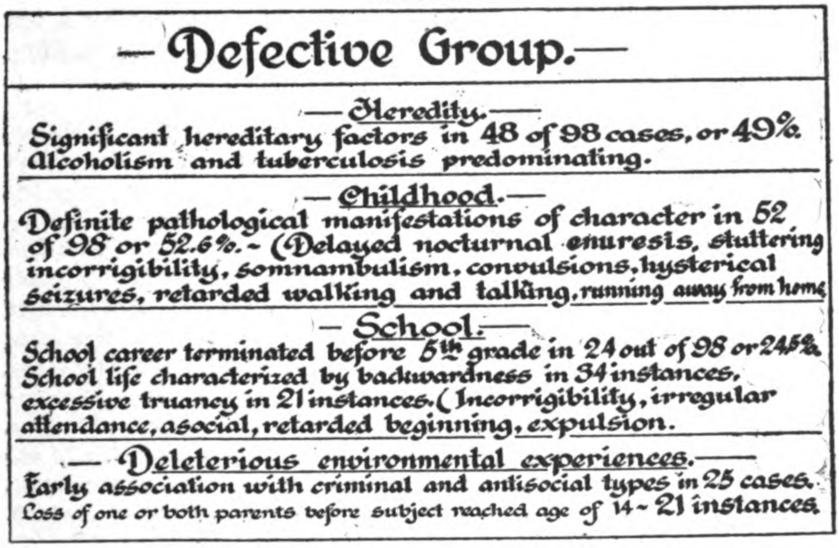
CHART 3

That the medical definition of this group does not rest exclusively upon laboratory tests of intelligence, the facts presented in this and succeeding charts amply prove. In fact, a considerable number of cases were handicapped even before they were born. Definitely harmful hereditary influences had been operative in 49 per cent of the cases, among which alcoholism and tuberculosis played a predominating rôle. In a substantial proportion of cases, on the other hand, the seriously twisted, later antisocial, careers might have been anticipated and corrected long before they actually became fixed. Definite pathological manifestations of character during early childhood came to light in 52.6 per cent, the grave import of some of which should not have been ignored, certainly not while these children were under the control and supervision of the public school. Such important danger signs as backwardness, leading to repeated failures, excessive truancy, incorrigibility, asociability—traits leading in some instances to expulsion, and in others to direct transfer to reformatory institutions—might well have deserved more intelligent attention than they apparently received. It is neither just to the individual, nor expedient socially, nor good business management for the community, to have ignored them. Such indifference on the part of organized society would perhaps have resulted less disastrously, were one dealing with more favorably circumstanced individuals who had enjoyed the benefits of protection of proper home and attachments. But the constitutional burden which these unfortunates were carrying was, in most instances, aggravated by vicious environment and contacts, or by the deprivation of the guiding hand which sustains the child in the normal family home. In 21 instances these children were left without one or both parents before reaching the age of fourteen.

CHART 4

The influence of early subjection of mentally deficient individuals to correctional discipline upon the shaping of their life-careers is too often the reverse of helpful. Fifty-eight per cent of these individuals had been in juvenile reformatory institutions on one or more occasions. It is not easy to evaluate justly the repressive and stultifying influence which these institutions may have exerted on the development of these men with infant minds. But that they were not reformed in respect to their antisocial tendencies is proved by the fact that today they are among the least promising subjects of our attention in a state prison. They are unprepared industrially to cope with life's demands, 83.7 per cent of the group being unskilled laborers. They have not developed habits of life such as might have counteracted their antisocial tendencies and expressions, as is shown by the fact that 31 were excessively alcoholic, eight were drug addicts, and 21 had been infected with syphilis. It is but fair to relieve the reformatory institutions of the serious indictment which these facts might imply. It is also fair, however, for society to acknowledge its own shortsightedness in the administration of these cases, and to resolve that their social cost shall in the future be in large part avoided by making intelligent and early use of the scientific knowledge already available concerning them.

CHART 3



—Defective Group.—

—Heredity.—

Significant hereditary factors in 48 of 98 cases, or 49%. Alcoholism and tuberculosis predominating.

—Childhood.—

Definite pathological manifestations of character in 52 of 98 or 52.6%.—(Delayed nocturnal enuresis, stuttering incorrigibility, somnambulism, convulsions, hysterical seizures, retarded walking and talking, running away from home

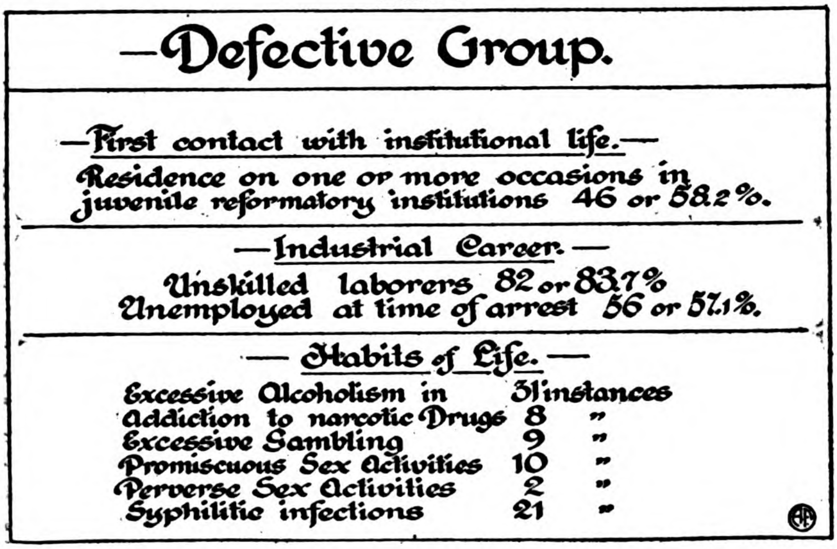
—School.—

School career terminated before 5th grade in 24 out of 98 or 24.5%. School life characterized by backwardness in 34 instances, excessive truancy in 21 instances. (Incorrigibility, irregular attendance, asocial, retarded beginning, expulsion.

—Deleterious environmental experiences.—

Early association with criminal and antisocial types in 25 cases. Loss of one or both parents before subject reached age of 14—21 instances.

CHART 4



—Defective Group.

—First contact with institutional life.—

Residence on one or more occasions in juvenile reformatory institutions 46 or 58.2%.

—Industrial Career.—

Unskilled laborers 82 or 83.7%
Unemployed at time of arrest 56 or 57.1%.

—Habits of Life.—

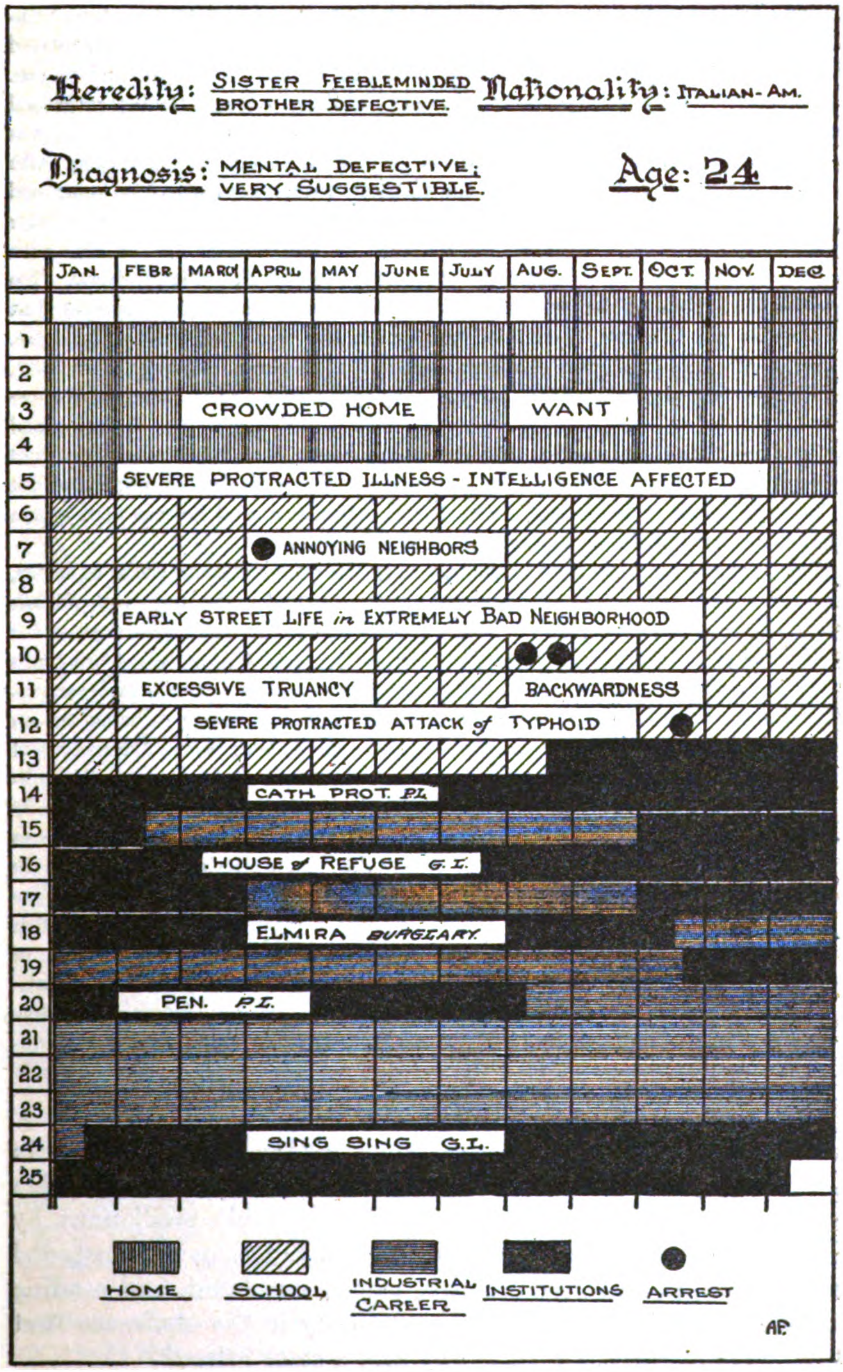
Excessive Alcoholism in	31	instances
Addiction to narcotic Drugs	8	"
Excessive Gambling	9	"
Promiscuous Sex Activities	10	"
Perverse Sex Activities	2	"
Syphilitic infections	21	"

CHART 5

For a more concrete appreciation of the foregoing statistical considerations, it may be helpful to supplement them by a few illustrations of the actual life performance of defective individuals with antisocial tendencies.

The twenty-four-year-old Italian-American, whose life history is charted on the opposite page, was born in a squalid home, in a congested section of New York City, of illiterate, simple-minded Italian immigrant parents, who had supported themselves by the combined earnings of the man as common laborer, and of the woman as finisher of garments for a sweatshop. They led a primitive, almost vegetative existence, acquired only a few simple English words during their residence of thirty-odd years in the United States, and remained un-Americanized either in spirit or in form. Of the thirteen children born of this union, four were miscarriages; a 27-year-old daughter is profoundly feebleminded, still unable to tell time or make simple change and totally illiterate; a boy, aged 25, formerly a member of the ungraded classes, is to a marked degree defective, is described by his school principal as "slightly unbalanced in mind, wild and uncontrollable," and has a juvenile court record. The subject of our present discussion, seventh in sequence, was born in New York on August 29, 1893. The mother, though over-burdened with heavy domestic cares, was obliged to continue her share of industrial labor for the support of the home during her pregnancy with this child, as was the case also with her other pregnancies. His birth and early infancy appear to have been uneventful. His general development appeared normal up to the age of five, when he was seized with whooping cough, and later with a protracted attack of what appeared to be either scarlet fever or some form of meningitis. Recovery was slow and tedious and left him dull and markedly reduced mentally, necessitating a re-learning of walking and talking. On reaching eight, he had a severe attack of acute rheumatism, which invalided him for seven or eight months, and at the age of twelve was confined to the Kings County Hospital with a severe protracted attack of typhoid fever, that still further reduced him physically and mentally. The effect of these severe inroads upon his health were reflected in his conduct at home, at school, and in the street. His mind at times seemed flighty, he was secretive, moody and uncommunicative. At school he was dull, inattentive, excessively truant, failed of promotion twice, and finally had to be sent to a truant school, and later to the Brooklyn parental school. From early boyhood he came in contact with a totally unsupervised street life in a vicious neighborhood. Thus, to the environment of a squalid, dark, unsanitary and crowded home, without bathing or toilet facilities in an old tenement building, there was added the influence of close contact with a neighborhood described by our investigator as follows: "Many cafés in the neighborhood frequented by bums who spoil boys. There is much drunkenness to be seen, many pickpockets, and not a few murders. In the neighborhood school across the street, fifty or more boys are on parole from the Children's Court." It is therefore not surprising that he early contributed to the police activities of the neighborhood. When not quite seven years of age, he was arrested in company with his brother for annoying neighbors. When not quite ten, he was arrested for thieving but was discharged for lack of suffi-

CHART 5


Heredity: SISTER FEEBLEMINDED BROTHER DEFECTIVE.
Nationality: ITALIAN-AM.
Diagnosis: MENTAL DEFECTIVE; VERY SUGGESTIBLE.
Age: 24
JAN.
FEBR.
MARCH
APRIL
MAY
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25
CROWDED HOME
WANT
SEVERE PROTRACTED ILLNESS - INTELLIGENCE AFFECTED
ANNOYING NEIGHBORS
EARLY STREET LIFE in EXTREMELY BAD NEIGHBORHOOD
EXCESSIVE TRUANCY
BACKWARDNESS
SEVERE PROTRACTED ATTACK of TYPHOID
CATH. PROT. P.L.
HOUSE of REFUGE G.L.
ELMIRA BURGLARY
PEN. P.L.
SING SING G.L.
HOME
SCHOOL
INDUSTRIAL CAREER
INSTITUTIONS
ARREST
AF

cient evidence; later in the same month he was again arrested, this time for having thrown bricks at workmen in the neighborhood and for smashing windows, and received a suspended sentence. At the age of twelve he was arrested in company with several other boys for having driven off with a horse and wagon. The owner did not care to prosecute the case and the problem of the boy remained for the nonce in abeyance. But it was only several months later that he was again arrested for having stolen some books from a bookstore in company with some other boys, and was sent to the Catholic Protectory, where he remained about a year and a half. The high degree of suggestibility which was later defined by laboratory methods was reflected in his behavior by the ease with which he was led into mischief by the other boys of the neighborhood. No record of his behavior at the Protectory is available beyond the statement that he was in good health, could read and write, and was confirmed while there. At any rate, no significant change in conduct took place following his release, and seven and one-half months later he was committed to the House of Refuge for breaking into a fruit and grocery store with some other boys. He remained at this institution one and one-half years, when he was released after work had been found for him. His capacity to avoid conflict with the law improved not a bit as a result of his second institutional experience, and he was at freedom only six months when he was sent to Elmira for burglary.

The monotonous repetition of the failure on the part of diverse social agencies, such as school and truant officials, police and court officials, and even officials of institutions of reformatory intent, where the boy was under observation for prolonged periods of time, to appreciate clearly the persistent causes of this boy's difficulty raises the question of the social responsibility for criminal careers. His contact with Elmira served for the first time in his career to bring out an effort at understanding on the part of society. He is described in the records of that institution as "a coarse type of Italian-American, of good physical condition, poor mental capacity, poor susceptibility, poor appreciation, a mentally defective pervert whose lack of parental control during formative period was undoubtedly the direct cause of his downfall; an undersized neurotic with little or no working capacity, whose low moral status precludes the possibility of continuous effort. Properly environed, under intelligent supervision, this juvenile delinquent might have become fairly self-supporting. The absence of incentive, however, coupled with a congenital defect, indicates a life of anti-social activities." He gained his parole in the usual time, maintaining average record. Again, his release on parole from the institution was a mere act of routine and in nowise signified his reformation. His subsequent history has fully justified the predictions made at Elmira.

Is it, we may ask, enlightened policy for the state to hamper in its efficiency and thwart in its purposes a reformatory institution which is capable of rendering such dependable predictions by forcing it to choose between assuming the functions of a custodial asylum for its defective inmates, on the one hand, and sending them out at the earliest legal opportunity in the assurance that they will presently find their way into a state prison?

Upon his release from Elmira, the boy under discussion immediately resumed his former mode of life, was arrested on suspicion several months later, and a year later was sent to the penitentiary for about nine months for thieving. In serving his present sentence in state prison for grand larceny, he has reached the last in the round of reformatory and penal institutions which this state provides. That not a single one of these institutions has succeeded thus far in accomplishing either the reformation or the permanent segregation of this defective boy, ought to raise serious doubt as to whether any one of them was appropriately equipped or intended for dealing with the peculiar social problem presented by him, although they seemed to satisfy the statutory requirements of temporary incarceration each time that he came in conflict with the law.

His industrial career has been a total failure thus far. Although in each reformatory institution an attempt was made to teach him a trade, it does not appear that he ever even attempted to work at any of these trades. His preference has always been for driving trucks and wagons, and when he was asked in the course of the examination what his ambition in life has been, he said, "I am crazy about automobiles." At one time he had accumulated $200, which he invested in a motor-cycle; the boys persuaded him to exchange it for a motor boat, and in the transaction he lost all his savings. In fact it never required much urging on the part of "the boys" to get him to do things. He realizes subjectively his incapacity to resist suggestions. "All the fellows have to say is, 'Go on, Joe, don't be a coward,'" and he is ready to do anything.

We found him to be fairly well developed and well nourished physically, and aside from valvular disease of the heart, and deviated septum of the nose, free from disorders. Mentally he is very infantile, overcredulous and dependent in make-up. In reply to a request, he wrote the following letter:

"Dear Sir:

I am writing you this letter to let you know that I am feeling fine hoping you the same and in best of health. I was sent hiar for Att G. L in the 2nd for 1 years and 11 months. I am going to be good and get out as soon has possible. I was send hear for Stealing a car, I would like to work wear I could learn more things about cars, because I was always around cars. I will close my letter by doing so I send you my best regards and wish you in the best of health. From your truly."

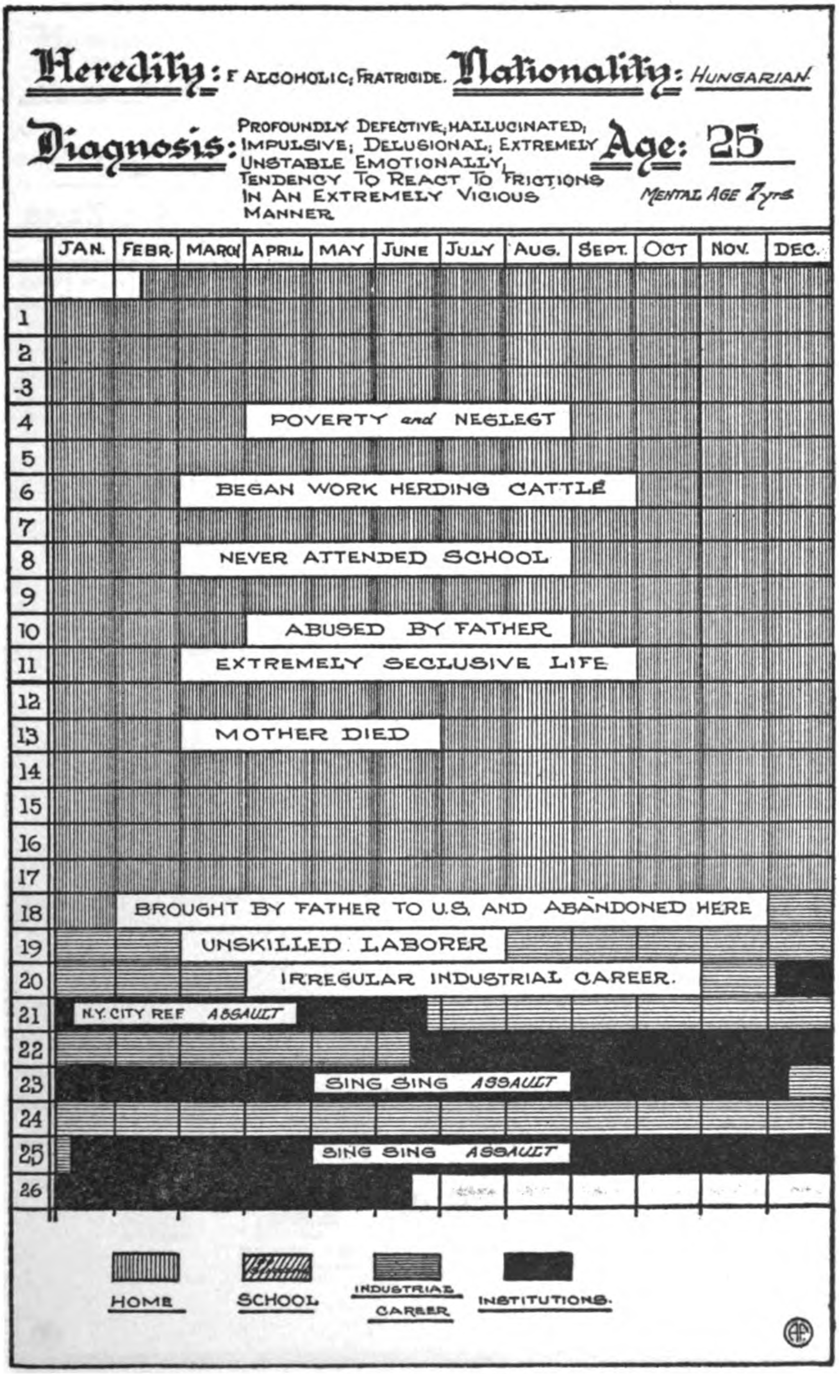
He co-operated well in the examination but was deliberately untruthful about certain matters and unable to give a correct account of others. His flow of talk was free, at times irrelevant and excessively circumstantial. He laughed childishly in relating his troubles and was unconcerned about his incarceration beyond an intention "to be good and get out as soon as possible." He has very little insight into his twisted career and attributes his delinquencies to "the boys" who always made him do things. He never stole anything alone. He is afraid of the dark. People used to scare him with skeletons. Before he would steal he would have a peculiar feeling of nervousness which he attributes to fear rather than anything else. His parents were good to him, although his mother was unusually severe and would administer a severe beating on frequent occasions. He loved to travel in automobiles, and when the boys suggested a joy ride, he stole the car.

The parents described him as mischievous, fond of children and animals, and say that he was always bringing dogs home. Moving pictures claimed a lot of his attention. Laboratory examination shows him to be defective in general intelligence, memory and learning ability very poor, learning chiefly by imitation, flow of free associations retarded, and a certain degree of oversuggestibility. In a psychometric estimation he attains a score of 67 per cent out of a possible 100, an intelligence age of about eleven. His present sentence will expire within a few months. What shall then be done with him?

CHARTS 6, 7 AND 8

It is hoped that these three charts, illustrating the life performances of defective individuals, will demonstrate the social risks involved in continuing to administer these problems in the way in which they have been handled in the past. Owing to the necessary limitations of this paper, complete reports of the case histories cannot be included.

CHART 6

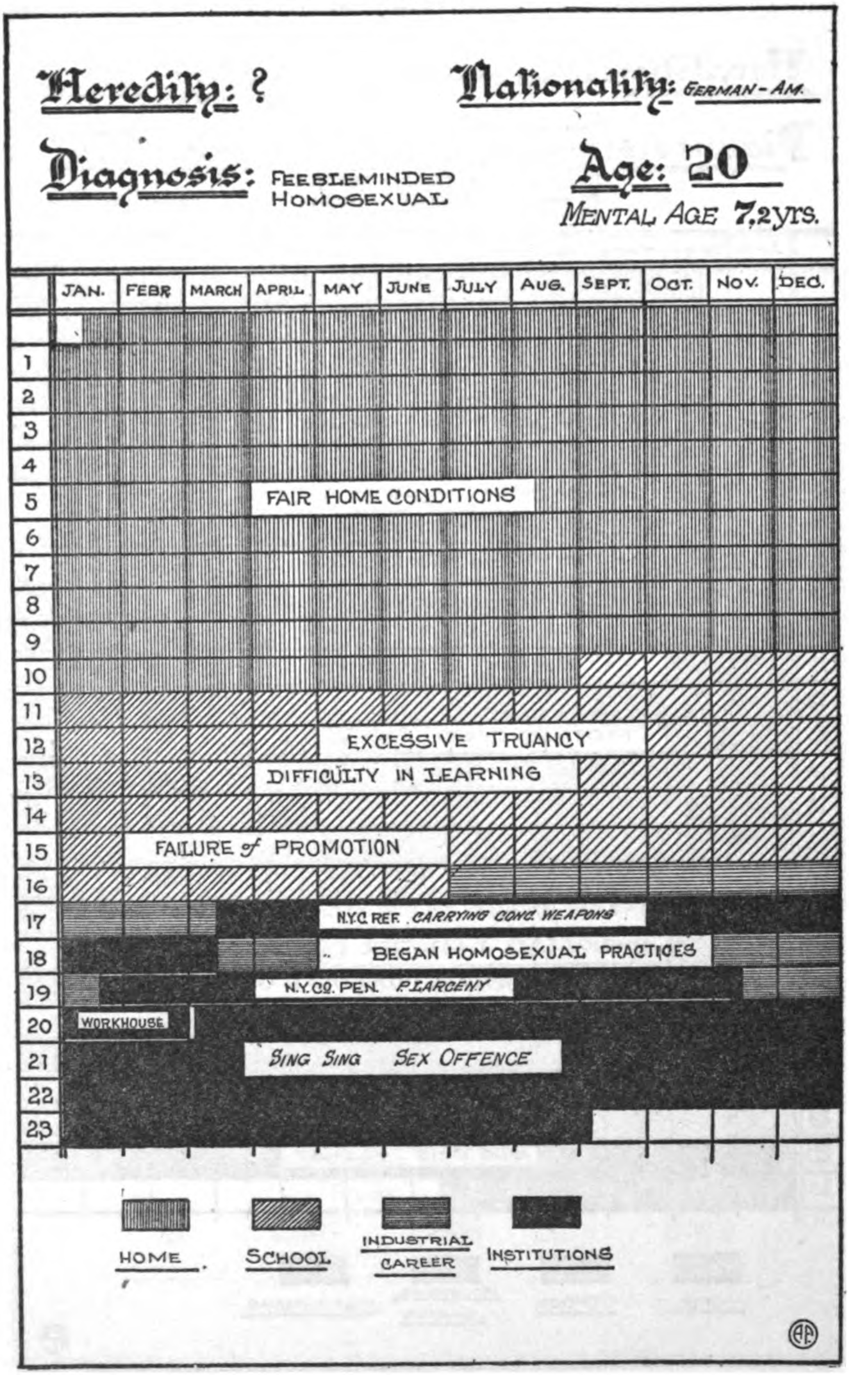


Heredity: F ALCOHOLIC; FRATRICIDE. **Nationality:** HUNGARIAN.

Diagnosis: PROFOUNDLY DEFECTIVE; HALLUCINATED; IMPULSIVE; DELUSIONAL; EXTREMELY UNSTABLE EMOTIONALLY, TENDENCY TO REACT TO FRICTIONS IN AN EXTREMELY VICIOUS MANNER **Age:** 25

MENTAL AGE 7 yrs

CHART 7


Heredity: ?
Nationality: GERMAN-AM.
Diagnosis: FEEBLEMINDED HOMOSEXUAL
Age: 20
MENTAL AGE 7.2yrs.
JAN.
FEBR.
MARCH
APRIL
MAY
JUNE
JULY
AUG.
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23
FAIR HOME CONDITIONS
EXCESSIVE TRUANCY
DIFFICULTY IN LEARNING
FAILURE of PROMOTION
N.Y.C. REF. CARRYING CONC. WEAPONS
BEGAN HOMOSEXUAL PRACTICES
N.Y.CO. PEN. P.LARCENY
WORKHOUSE
SING SING SEX OFFENCE
HOME
SCHOOL
INDUSTRIAL CAREER
INSTITUTIONS

CHART 8

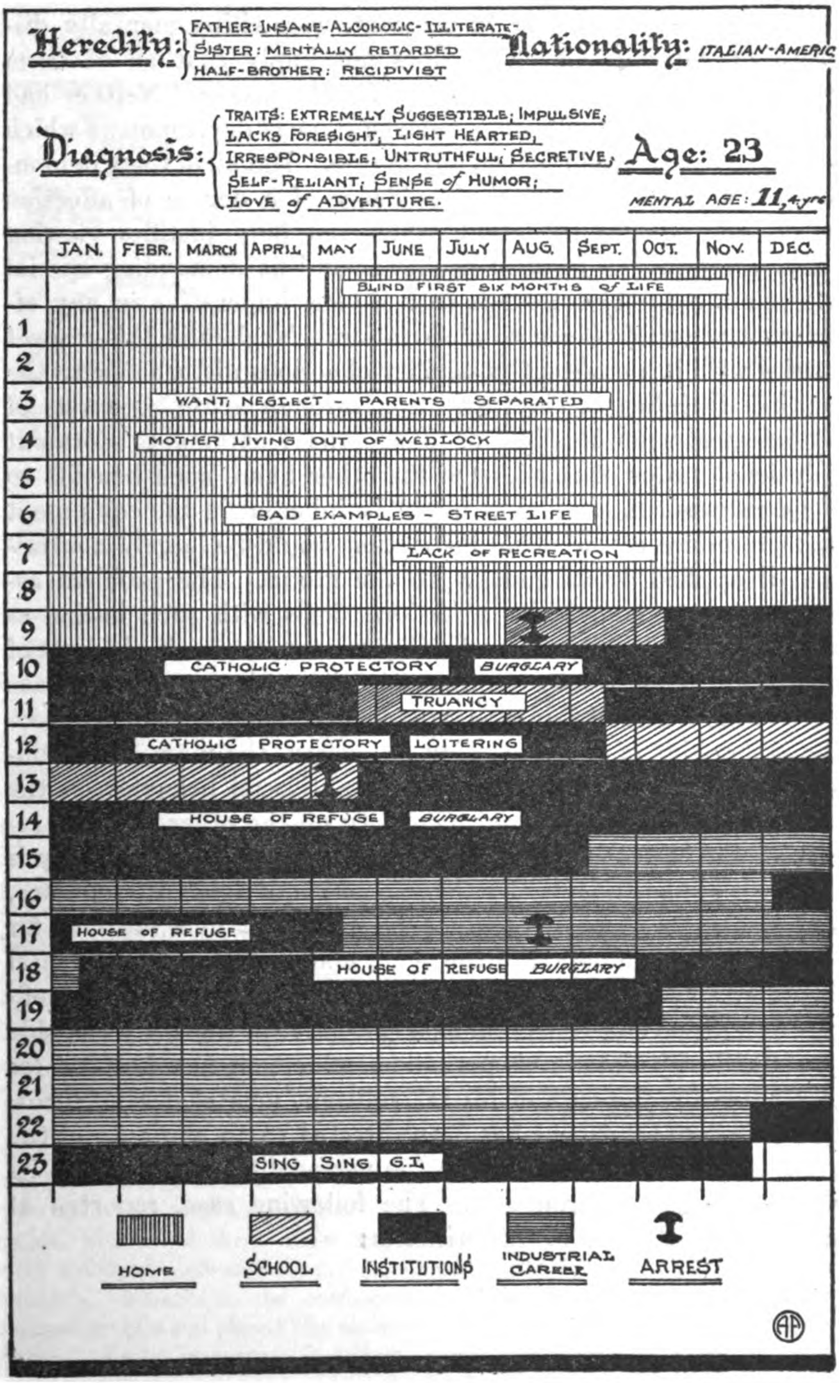

Heredity:
FATHER: INSANE-ALCOHOLIC-ILLITERATE-
SISTER: MENTALLY RETARDED
HALF-BROTHER: RECIDIVIST
Nationality: ITALIAN-AMERIC
Diagnosis:
TRAITS: EXTREMELY SUGGESTIBLE; IMPULSIVE;
LACKS FORESIGHT; LIGHT HEARTED;
IRRESPONSIBLE; UNTRUTHFUL; SECRETIVE;
SELF-RELIANT; SENSE of HUMOR;
LOVE of ADVENTURE.
Age: 23
MENTAL AGE: 11,4 yrs
JAN.
FEBR.
MARCH
APRIL
MAY
JUNE
JULY
AUG.
SEPT.
OCT.
NOV.
DEC.
BLIND FIRST SIX MONTHS of LIFE
1
2
3
WANT; NEGLECT - PARENTS SEPARATED
4
MOTHER LIVING OUT OF WEDLOCK
5
6
BAD EXAMPLES - STREET LIFE
7
LACK OF RECREATION
8
9
10
CATHOLIC PROTECTORY
BURGLARY
11
TRUANCY
12
CATHOLIC PROTECTORY
LOITERING
13
14
HOUSE OF REFUGE
BURGLARY
15
16
17
HOUSE OF REFUGE
18
HOUSE OF REFUGE
BURGLARY
19
20
21
22
23
SING SING G.I.
HOME
SCHOOL
INSTITUTIONS
INDUSTRIAL CAREER
ARREST
AP

CHART 9

Of the 608 cases 73, or 12 per cent, were either mentally diseased or deteriorated. This does not imply that all of them required confinement in a hospital for the insane. Neither had the condition in all of them reached a stage of development which would have rendered them legally insane. But all of them demonstrated unmistakable medical evidence of a degree of affection or deterioration of the mind, which not only justifies viewing them primarily as medical problems and as demanding special attention, but which renders such a view imperative in any efficient system of prison administration. Neglect in this respect carries with it a constant possibility of serious disturbance to the routine discipline of the institution through acute outbursts of pathological emotionalism or dangerous reactions to dormant delusional states of mind. On the other hand, such benefits to the delinquent individual as might be inherent in the equipment and procedure of the penal institution would be largely neutralized if applied promiscuously to the group. The problem assumes a new complexity when one deals with such insane as possess criminal tendencies. While here, too, the medical aspect of the problem is usually paramount, the serious social menace inherent in a case of this type must be taken into account. From the standpoint of the protection to society, the man whose constitutional disease expresses itself in antisocial behavior on the one hand, and in disordered mentality on the other, has not received adequate attention when the one phase of his difficulty is dealt with independently by the imposition of a definite sentence, and the other phase by temporary treatment in a hospital for the insane for the period of the acute manifestation of his mental disorder. The method of periodic sentencing to prison for definite terms is no more effectual as a corrective of the antisocial side of his make-up than is his periodic confinement in a hospital for the insane for the cure of his intermittent mental derangement. In either case treatment has been directed to an attribute of the diseased personality and not to the personality as a whole in its relation to the environment. The following case, reported at length, is illustrative of this criticism:

CHART 9

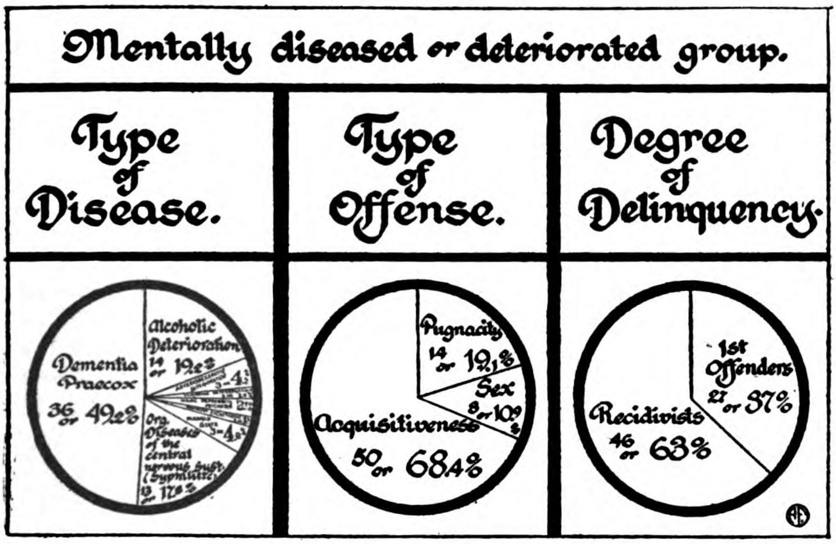
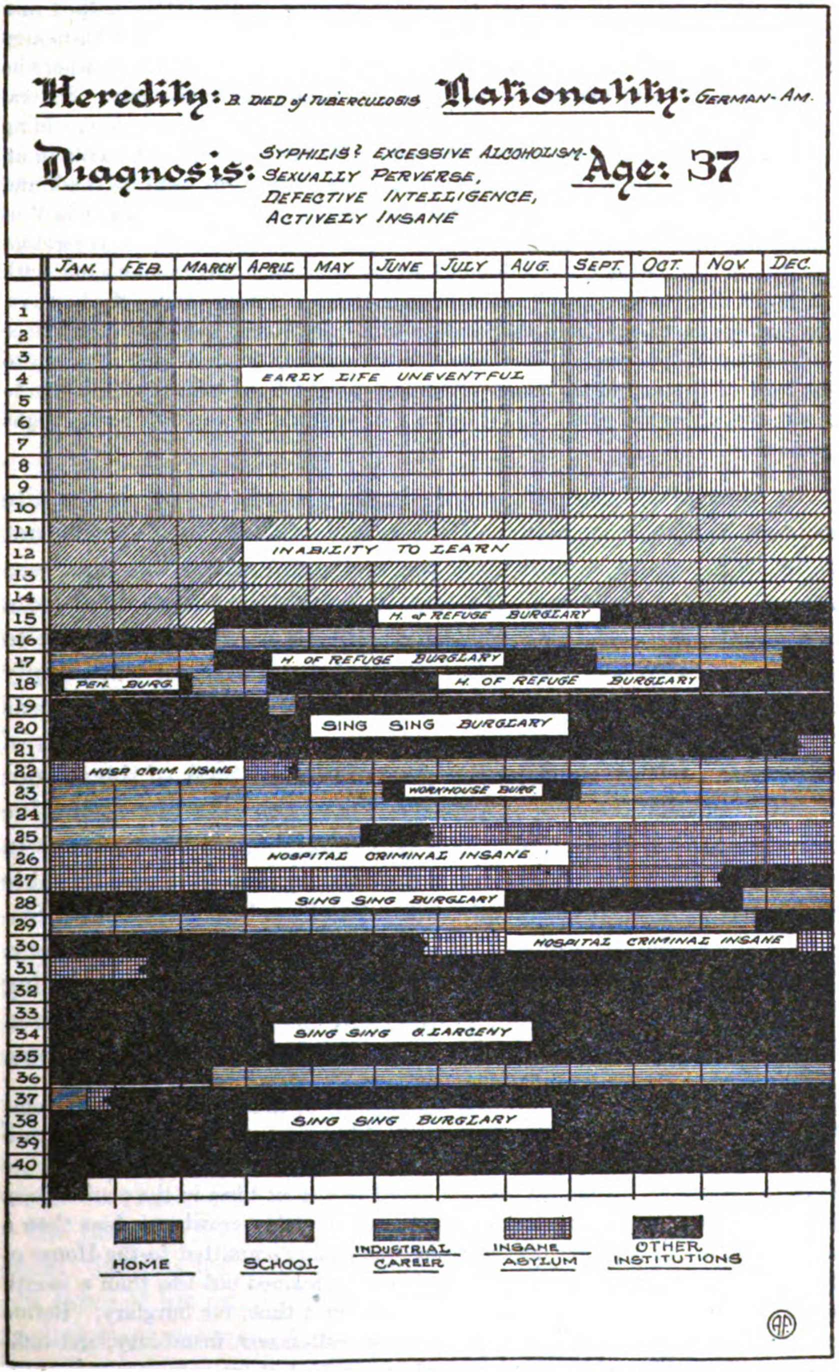


CHART 10

This thirty-seven-year-old German-American's reception at Sing Sing constitutes his fourth admission to state prison, and his ninth to penal and reformatory institutions of various types. His ancestry appears free from taint, but a half-brother died of pulmonary tuberculosis. The parents are industrious, law-abiding citizens, and some members of the family have attained prominent social position. The inmate is the youngest of ten children, three of whom died in infancy. Birth and infancy were normal, home conditions during early boyhood favorable, but street and neighborhood environment very bad, and his preference for the company of the more wayward and abandoned boys in the neighborhood led his parents to send him to live for a time with an uncle in a small town in New Jersey. While serious antisocial tendencies did not become manifest until the beginning of adolescence and after he had sustained severe injuries in consequence of an explosion in a factory where he was employed, long before this his conduct was different from that of the other children in the house and as such provoked severe disciplinary measures at the hands of his parents notwithstanding the fact that, as the youngest in the family, he was more or less pampered by relatives and parents. His school career between the ages of six and thirteen was characterized by inability to learn and excessive truancy, and terminated in the fourth or fifth grade. Attempts to improve his education were made in several ways by the parents who were anxious to give him an education, but all of these ended in failure. At about this time he began to show a distinct preference for unsupervised street life, and to associate with the antisocial elements in the neighborhood. The parents became very much alarmed at this and placed him under the charge of an uncle, as stated. Here he went to work in a pyrotechnic factory where, soon afterwards, an explosion occurred killing several boys and inflicting burns about the face and back of the inmate. After several months in a hospital in Jersey City, he returned home and to the old neighborhood. Parents and relatives state that after his recovery he never seemed the same as before, and at times evinced a mania for stealing. At first the family tried to help him overcome these inclinations, "but he was so ready to steal and made such desperate threats even to kill," that when he came to the door of his own home or to that of neighbors, he was given practically whatever he wanted and chased away. During the investigation of the case, the sisters and brothers recalled vividly the terror he had caused and what a relief it was to them to know that he was locked up and prevented from doing them harm. A florist in the neighborhood tells how, as a youngster, the inmate came to his shop and informed the boy in charge how he could crack the safe, break open the door, knock the man over the head, etc., and that he felt obliged to guard his store until midnight, from fear that the threat would be carried out. A similar story is told by a confectioner in the same block. One time, before the inmate was fifteen, he sent a note to an aunt purporting to be from her husband, to the effect that he, the husband, had met with a serious injury, was at a hospital, and wished her to come at once. The aunt who, as janitress of the house, frequently kept large sums of rent money in her room, and had long feared that the boy would try to rob her, recognized his handwriting and frustrated his plan. His home conditions at that time were fair, he was given a fair allowance in addition to what he was able to earn, and did not appear to have need of the money, but relatives emphatically assert, "he seemed to have a mania to have a lot of money quick." The father argued with him about his habits, deliberately gave him money to forestall his stealing, but apparently to no avail. Occasionally, while employed, he would bring his wages home, throw them on the floor as though spurning them, and later would pick them up and spend them all at once. He showed a distinct preference for robbing relatives and places where he was well known, and seldom attempted at that time to rob strangers. While attending school and before he had reached the age of twelve, he was arrested on the complaint of the school janitor that he had stolen slate pencils from a school desk, but the case was dismissed. When not quite fifteen he was the subject of a sensational arrest for having attempted to rob the ticket office of a touring agency. The events which led to this attempted burglary were related by him at that time as follows:

"I took $4.69 from father's drawer Friday night and went on a train to Yonkers, when all the boys said I ought to go West and see Fitzsimmons and Corbett fight. I came back to New York. As I hadn't enough money to go West, I tried to win it from boys shooting craps, but they knew too much. I found the hatchet Sunday night, and the ticket office as I was passing was tempting. I would have taken a ticket to Carson City and some money perhaps and the people would not have missed the ticket or the money, but the policeman caught me." (Newspaper clipping, 1897.) When detected he was trying to break the combination of the safe. At the time of this arrest the father stated that the boy had never acted right since the injury about two years previous. He would constantly get into trouble, stay only for a short period of a few weeks on a job and quit, saying he was rich and didn't have to work any more. "Never seemed to have patience to stick to one thing any length of time. Wanted a change frequently; wanted to make money and lots of it, quick. Seemed to feel no

CHART 10


Heredity: B. DIED of TUBERCULOSIS
Nationality: GERMAN-AM.
Diagnosis: SYPHILIS? EXCESSIVE ALCOHOLISM-
SEXUALLY PERVERSE,
DEFECTIVE INTELLIGENCE,
ACTIVELY INSANE
Age: 37
JAN.
FEB.
MARCH
APRIL
MAY
JUNE
JULY
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40
EARLY LIFE UNEVENTFUL
INABILITY TO LEARN
H. of REFUGE BURGLARY
H. OF REFUGE BURGLARY
PEN. BURG.
H. OF REFUGE BURGLARY
SING SING BURGLARY
HOSP. CRIM. INSANE
WORKHOUSE BURG.
HOSPITAL CRIMINAL INSANE
SING SING BURGLARY
HOSPITAL CRIMINAL INSANE
SING SING G. LARCENY
SING SING BURGLARY
HOME
SCHOOL
INDUSTRIAL CAREER
INSANE ASYLUM
OTHER INSTITUTIONS
AF

responsibility to earn it but would go from one relative to another, demand money, and make threats if it were not given him at once." His father helped him out so many times he came to feel it was due him to be supplied with money when he wanted it. The boy was committed to the House of Refuge, where he soon became ill and had to be transferred to a hospital in the city. Several months after commitment, he escaped by climbing through a window, sliding down a fire escape, and scaling a high fence. He beat his way to Canada in an express train, remained there for some time knocking about until he tired, and beat his way back to New York. While staying at the house of a sister in Williamsburg, one of the roomers took exception to the manner in which he foretold her future, and during the ensuing quarrel he threatened this woman's life, with the result that a police officer was summoned for his arrest. When the boy saw the policeman, he ran from the kitchen to a front room, unlocked a hall door and hurried to the roof. When arrested, he was just endeavoring to climb to the roof of the adjoining house. The boy fought hard before submitting to arrest and afterward said, "If I'd had a gun with me he wouldn't have caught me so easy."

In view of subsequent events in this man's career, it is quite evident that the suspicion of his relatives that the boy was not right in his mind should have received more attention than was accorded it at the time. In fact, it cannot be ascertained from a diligent search of the records that any effort at all was made to determine why this boy acted as he did. The case was simply dealt with as an ordinary case of burglary and the sentence was fitted to the criminal act in accordance with the requirements of the statute. This persistent neglect of the boy back of the act not merely prevented a proper appreciation of the kind of reformative training and discipline of which this particular individual was in need—an omission which in all probability has had considerable influence in fixing his criminal tendencies—but it has also imposed a prodigious amount of expense and injury upon society. For proof it is sufficient to cite the fact that in addition to serving his ninth term in a penal institution, he has already required treatment in a hospital for the insane on three different occasions.

It is difficult to estimate precisely the number of times he actually has come in conflict with the law. By no means all of his numerous arrests have terminated in commitment to institutions. Less than ten months after his release from the House of Refuge, he was sentenced to a short term in the penitentiary for having knocked a woman down in the street with a crowbar. Less than a month and a half after his discharge, he was again committed to the House of Refuge for a year for burglary. This time he remained out less than a month when he was committed to Sing Sing for the first time, for burglary. Before completing this sentence, however, the same restlessness, instability, and difficulty of adaptation, which characterized his conduct at freedom, asserted itself, only in an accentuated form because of the more rigid demands placed upon him by prison life, and he had to be transferred to the State Hospital for the Criminal Insane. The medical certificate of the physician at Auburn stated that the patient was violent and homicidal. He had struck a fellow convict on the head because he would not gratify his perverted sexual desires and threatened to kill him because he would not comply with his demands. "He is unreliable, untruthful, vicious, revengeful, cowardly, destructive, and troublesome. It has been tried in every manner to make something of him, but kindness, coaxing, and punishment have so far failed." At the hospital for the criminal insane he seemed silly, talked much of sexual matters, said that girls visited him at night, and masturbated much. After about a month, he gave up many of his beliefs and seemed to exhibit very little but mental deficiency. His term of sentence expired, and as the father offered to give him a home and sent money for him, he was put on a train for New York City. He was discharged as "improved;" diagnosis, "chronic mania."

What a naive solution for so serious a problem as this man even then constituted! Manifestly the medical profession showed as little comprehension of the social aspects of the problem as had the legal profession. Both concerned themselves with symptoms: the one dealt with the criminal act by prescribing confinement for a definite period in a penal institution, and the other considered its duty performed in treating the occasional outbreaks of his twisted personality; when the father sent money for his transportation and offered to take him home, the expiration of his sentence was made the occasion for discharging him, albeit only as "improved." It is but fair to add that had the hospital authorities recognized the danger of releasing this man and attempted to hold him longer, they would in all probability have encountered much opposition in the form of habeas corpus proceedings, might have been placed on the defensive by a clever lawyer, and ultimately the man would doubtless have been ordered discharged by court order, since with the subsidence of the overt and obvious signs of his aberration, he was no longer legally insane. But, it may be asked, Was the procedure justified? At the time of his release from the first term in a hospital for the insane he was twenty-one. He is now thirty-seven years old, and during the intervening sixteen years he has been sent to state prison on three different occasions, each time requiring transfer to the hospital for the insane before the termination of his sentence. He has led a totally unproductive, viciously criminal life —in some of his criminal escapades not stopping short of assaulting helpless women. He has been excessively and habitually alcoholic and has led an extremely promiscuous sex life, and today the problem which he presents to society is no nearer solution than it was twenty years ago despite the vast, if unintelligent, expenditure of money and effort in the attempt to administer it. We say "administer it" advisedly, for there never seems to have been any genuine attempt to solve it. The question in the minds of those who have had this man under their charge has apparently been: "What shall we do to him," rather than: "What shall we do with him?" From a study of his career, one cannot escape the conviction that the reconstructive issue it presents has never been duly recognized by those who had responsibility for its shaping.

Take for example, his last crime and conviction. The man had been befriended by a woman. She furnished him lodging at her house, and while she was away he robbed her of her jewelry and money. He was arrested and held for trial by a grand jury in a community where his past criminal record was well known. A consideration of the man rather than of the act would have involved attention to his past career, a career which, even apart from the fact that the man had in the past required repeated treatment in a hospital for the insane, certainly would have justified the judgment of habitual criminality and as such required the application of the law providing permanent segregation of the habitual criminal. The application of such sentence, while not doing justice to the specific medical needs of the case, would at least have disposed provisionally of the social problem involved and would have rendered adequate protection to society against the continued depredations of this man. Instead of this, the District Attorney's office, for the sake of a quick and cheap conviction, enters into a bargain with the burglar inducing him to change his original plea from not guilty to guilty of burglary in the second degree, and he is given one more pill of punishment in the form of a definite sentence of 4 years and 11 months in prison.

If we endeavor to estimate the human individual back of this burglary, we find him to be well-developed anatomically, but looking physically ill and showing evidence of a former syphilitic infection, besides certain neurological signs pointing to involvement of the central nervous system. Pupils react very sluggishly to light stimulus; there is marked swaying of body on standing with eyes closed, deep reflexes markedly exaggerated. Mentally he is sullen, uncommunicative, memory for remote events very confused and unreliable, attention difficult to hold for any length of time, and the slightest persistence of mental exertion produces much fatigue, irritability and sullenness. His attitude towards his criminal career is colored considerably by an intense paranoid interpretation of his conflicts with the law and law officers. He speaks very bitterly of two detectives who had been following him constantly for several years. They made him go from place to place and from occupation to occupation in his effort to avoid them. They have been more active in their efforts to locate him during the past ten months, and wherever he would go to work he would see them about. Night before last he had seen one of them in the dormitory of the prison hospital. The man was standing near his bed and threatened to kill him, and told him that he would come every night until he informed him where the jewelry was that he had stolen. Last night he took some pills that he might sleep soundly and avoid a similar experience. He threatens to smash up everything in the dormitory if the detective should visit him again. He actively rejects the suggestion that he probably imagines a good deal and says he'll make sure this time that he's not railroaded into the insane asylum. But while his assertions concerning the persecutions leave one somewhat in doubt as to what effect these beliefs have on his state of feeling, his recital of life's experiences in general bears a strong coloring of suspiciousness and apprehensiveness concerning his contacts with the police. He is depressed emotionally, tired and without energy, and impresses one as being physically ill. His stream of talk is considerably retarded and laborious, productivity careless. His attitude towards the examiner is sullen and unfriendly; he suspiciously watches the latter's movements, and frequently looks over his own shoulder as if wanting to see whether someone were watching him. In his behavior in prison he shows the same sullenness, is seclusive, and holds himself aloof from the other prisoners and does not make any confidants. Estimation of his intelligence is unsatisfactory owing to lack of active co-operation and difficulty of holding his attention. He tires perceptibly upon mental exertion. In the performance tests he fails after working on a simple task for five minutes, makes thirty-five moves repeating frequently illogical moves, shows no capacity for learning from experience, repeats eighteen moves in the same careless, inattentive, haphazard fashion, and fails after six minutes. In the apperception test he makes five illogical substitutions, fails in the dot counting and cancellation tests and fails completely in reproducing ideas of passages read to him. Altogether he shows a very meagre intelligence by laboratory tests, is especially hampered by a confused memory, very poor attention, poor comprehension, and retardation of thought processes. He fails completely in trying to reproduce designs in the ten-year-old test.

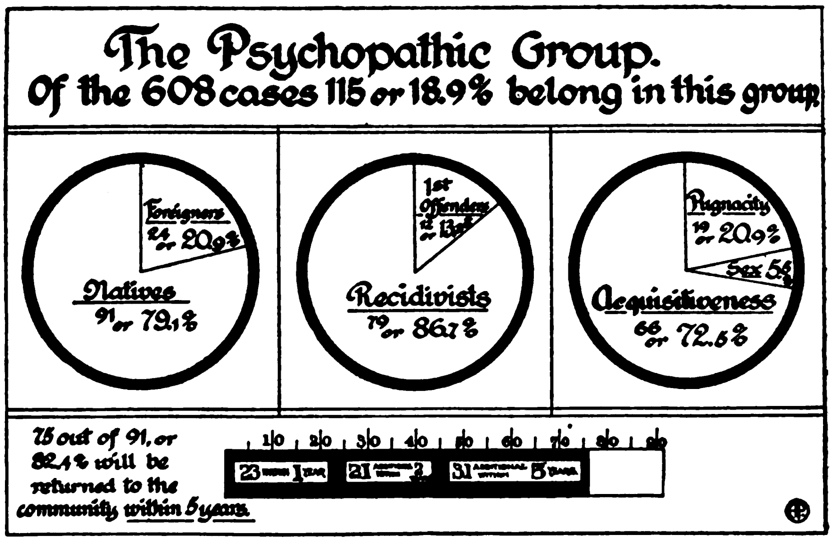
A description of the dominant traits of character given by parents and relatives is to the effect that he is bold and a dare-devil in his exploits, very egotistical, lacking all sense of responsibility, without ambition and without patience. He could always secure work and seemed to find jobs without difficulty. After two or three weeks, when paid off, he would say, "I'm rich—I don't need to work." Afterward he would steal or get another job. "His nerves seem to have been out of order. Is deceitful and cunning, fabricates wonderful tales in which he is the chief actor." It may not be out of order to note the opinion of his own family as to what should be done with this man, since they have quite an intimate interest in his career. They feel that he will always be criminal and are in fear of his committing murder. They would like to have him receive a long prison term or see him confined for life to some institution. This man's sentence will expire before two years pass. What does the state propose to do about him then?

CHART 11

The medical classification of this material into defective, insane and deteriorated, and psychopathic, was undertaken primarily for practical purposes. Some way must be had for simplifying this highly complex situation, and a classification based on the make-up of the individual prisoner's personality appears to be a promising approach, provided, of course, that the immediate object of prison management is the prisoner himself, and the practical test of its efficiency the measure in which it protects society, either through permanent improvement or through permanent segregation of him. The belief that there is need for a restatement of purposes is enforced by the facts already presented. Does it not seem, at least from the manner in which this human material has been handled in the past, that it has served all too commonly as grist for the mill of the criminal law and as a means for the vindication of general preconceptions and sentiments, rather than for the concrete purposes of social security and individual welfare?

Of the three groups in our classification, the psychopathic group demands most attention for several reasons. It is the most dangerously criminal class, showing the highest percentage of recidivism, 86.7 per cent. It is the most difficult class to recognize and define by means of objective pathological signs. Finally, it is perhaps the most promising group from a therapeutic point of view. It occupies a point midway between the mentally normal on the one hand, and the insane and defective on the other. While the psychopath may also be intellectually deficient, he need not be so, and while in the course of a psychopathic career necessity may arise for treatment in a hospital for the insane because of acute disorders of a mind already pathological, the majority of psychopaths never exhibit such breakdowns. Within the ranks of the psychopath belong those highly emotional and unstable individuals who go through life without steady goal or object, swayed hither and thither by whatever current may strike them, who easily fall a prey to vicious and deteriorating habits that sooner or later lead them into a life of criminality. The formation of unhealthy habits of life frequently results from a lack of counteracting, constructive guiding motives, the introduction of which into the lives of these men may serve to bring about a satisfactory change in behavior. Nevertheless, serious as is the social problem of the psychopath, and urgent as are the

CHART 11



demands for intensive individual attention, our usual procedure betrays no recognition of his great potency for good or evil. Of the ninety-one native Americans belonging to this group, 86.7 per cent of whom are recidivists, with an average record of 3.9 sentences, seventy-five or 82.4 per cent will have been returned to the general community within five years, uncured.

CHART 12

While in the early life of the intellectually defective it is not often possible to predict the degree of mental development ultimately attainable, the majority of psychopathic individuals show already in childhood and early boyhood, unmistakable signs of pathological personality. In our series of cases such early symptoms of psychopathy were evident in 86.6 per cent, the import of which should have been appreciated and acted upon at that stage. This is, of course, especially true of the school period, when marked deviation from average child behavior was manifested by 76.9 per cent of the cases. In 68 per cent of the cases a decided hereditary taint was present, the most common being alcoholism.

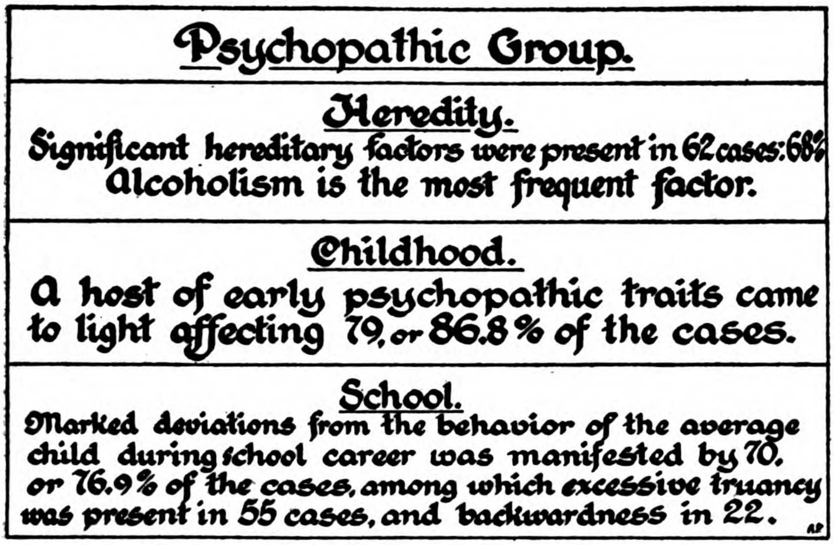
Whatever benefit may result for the treatment of the present state prison population from viewing it in the light of individual constitutional make-up, the most tangible advantage will be the clear demonstration that for effectually dealing with the problem, recognition and social control are imperative long before the individual reaches state prison. It is in the early formative period of life, especially during the boy's contact with the school system, that a better public appreciation of these danger signs is needed, and a disposition to institute the proper preventive measures. May we not see in the fact that so large a number of former school wards have turned out badly in their after-life performance, at once the failure and the obligation of our public school system to define its task not as the imparting of the three R's or other impersonal subject matter, but in terms of the needs of its real, living objects of education—the personalities of its individual pupils?

CHART 13

When we bring under review the adult period of these men's careers, we observe an accentuation of tendencies to irregular and to inefficient living that had already been foreshadowed in their earlier performance. Forty-one per cent of these psychopaths were excessively alcoholic, 23 per cent were drug addicts, 26 per cent were excessive gamblers, eight of them were sex perverts, and fourteen had acquired syphilis as a result of promiscuous sex activities. Although the most frequent age among them was only nineteen years, 32.6 per cent had already changed their type of occupation three or more times.

The law and its agents are wont to give exclusive attention to the criminalistic phase of these men's behavior. In so doing they ignore these less striking aberrations of impulse or habit and fail to see the particular antisocial act or crime against the background of the entire personality of the offender as disclosed by his history. A knowledge of this background is frequently essential and always valuable for a just estimation of the causes of his criminality and of the chances and conditions of his rehabilitation. The factors noted in the accompanying chart are in the nature of complications of the malady, and no disposition that neglects them can hope to lead to a cure.

CHART 12



Psychopathic Group.

Heredity.

Significant hereditary factors were present in 62 cases: 68%
Alcoholism is the most frequent factor.

Childhood.

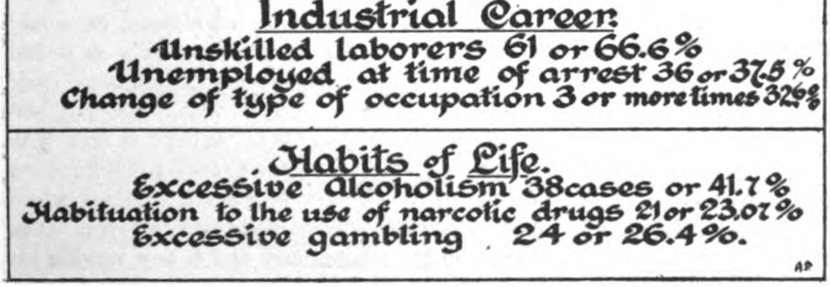
A host of early psychopathic traits came to light affecting 79, or 86.8% of the cases.

School.

Marked deviations from the behavior of the average child during school career was manifested by 70, or 76.9% of the cases, among which excessive truancy was present in 55 cases, and backwardness in 22.

AP

CHART 13



Psychopathic Group.

Sex Life.

Repeated recourse to perverse sex activities in 8 instances, markedly promiscuous sex life in 31 instances, syphilitic infection in 14 instances.

Industrial Career.

Unskilled laborers 61 or 66.6%
Unemployed at time of arrest 36 or 37.5%
Change of type of occupation 3 or more times 32.6%

Habits of Life.

Excessive Alcoholism 38 cases or 41.7%
Habituation to the use of narcotic drugs 21 or 23.07%
Excessive gambling 24 or 26.4%.

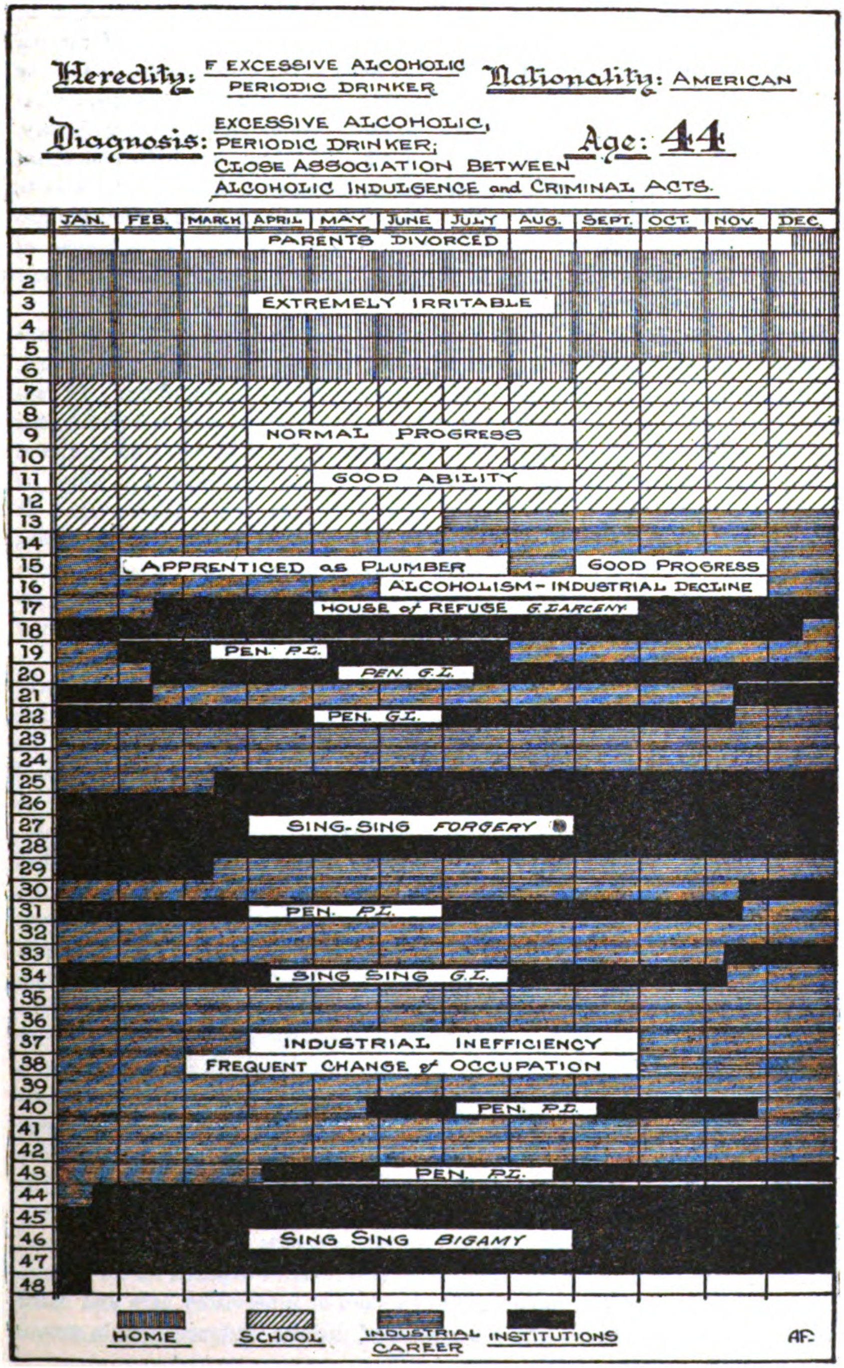
AP

CHART 14

This inmate who, at the age of 44, is already serving his tenth sentence in reformatory and penal institutions, is the scion of native American stock that has undergone considerable degeneration. The paternal grandfather, a colonel in the Civil War, led a normal, efficient life until his death from heart disease at the age of 70. The paternal grandmother died of senility at 80. Maternal grandparents came from England and spent their lives in New Jersey as prosperous farmers. The father, born in New Jersey, was strong and healthy during his early adulthood, but later, as captain of a schooner, became excessively alcoholic and promiscuous sexually and gradually deteriorated into an idle and lazy life, meeting death at 41 years of age from an unknown cause. His dissolute habits, after seven years of conjugal life, finally led to separation from his wife, who could not bear his sexual promiscuities, aggravated by his effrontery in expecting her to contribute to the support of his illegitimate offspring by various other women. At the time of the divorce, she was well advanced in her pregnancy with the inmate, and had been very unhappy and disturbed during the period on account of her husband's abandonment to alcohol and sexual excesses.

The birth and infancy of the inmate, according to his mother's statements, were uneventful, but he was "a very cross baby." The mother was comfortably situated in her own home and was able to meet satisfactorily their simple wants by doing a little sewing at home for others. He attended school between six and thirteen. It appears that he had no difficulty in learning, but was detained for two years in the fifth grade on account of excessive truancy. He was then obliged to leave school because the mother's economic status had declined somewhat and she needed his assistance. Apprenticed out as a plumber he began, coincident with his wider contacts, to indulge in alcohol, a habit that gradually gained a very strong hold upon him and affected his behavior in a decisive manner. The history of his extensive and persistent criminality and his decline in industrial efficiency are closely interwoven with his alcoholic habituation. At about this time the mother was obliged to move to Brooklyn where employment was more plentiful, and there he fell in with a gang of fellows who habitually resorted to criminal means for supplying their wants. He soon began to imitate their ways and activities and in his sober moments is inclined to attribute his lax, antisocial habits, to these early contacts. Alcoholic drink would render him ugly in disposition, quarrelsome and disrespectful, except to his mother. Occasionally, even when sober, especially in later years, he would suddenly grow very angry, but his anger would subside as quickly as it had been aroused. In later years, when the chronic ingestion of alcohol made itself evident in a change of personality, he became untruthful, vain, impulsive, and dishonest, and it is highly significant that every one of his delinquent acts, with the single exception of that which caused his first arrest, took place during a state of intoxication. His first arrest occurred when he was not quite seventeen and resulted in his confinement in the House of Refuge for twenty-two months. Since then he has served six terms in the penitentiary and is now serving his third term in a state prison. His crimes were invariably prompted by a desire for gain with the exception of the last offense, which was bigamy. His industrial career, although auspicious in its beginning when he undertook to learn the

CHART 14


Heredity: F EXCESSIVE ALCOHOLIC PERIODIC DRINKER
Nationality: AMERICAN
Diagnosis: EXCESSIVE ALCOHOLIC, PERIODIC DRINKER; CLOSE ASSOCIATION BETWEEN ALCOHOLIC INDULGENCE and CRIMINAL ACTS.
Age: 44
JAN.
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PARENTS DIVORCED
EXTREMELY IRRITABLE
NORMAL PROGRESS
GOOD ABILITY
APPRENTICED as PLUMBER
GOOD PROGRESS
ALCOHOLISM - INDUSTRIAL DECLINE
HOUSE of REFUGE G. LARCENY
PEN. P.L.
PEN. G.L.
PEN. G.L.
SING-SING FORGERY
PEN. P.L.
SING SING G.L.
INDUSTRIAL INEFFICIENCY
FREQUENT CHANGE of OCCUPATION
PEN. P.L.
PEN. P.L.
SING SING BIGAMY
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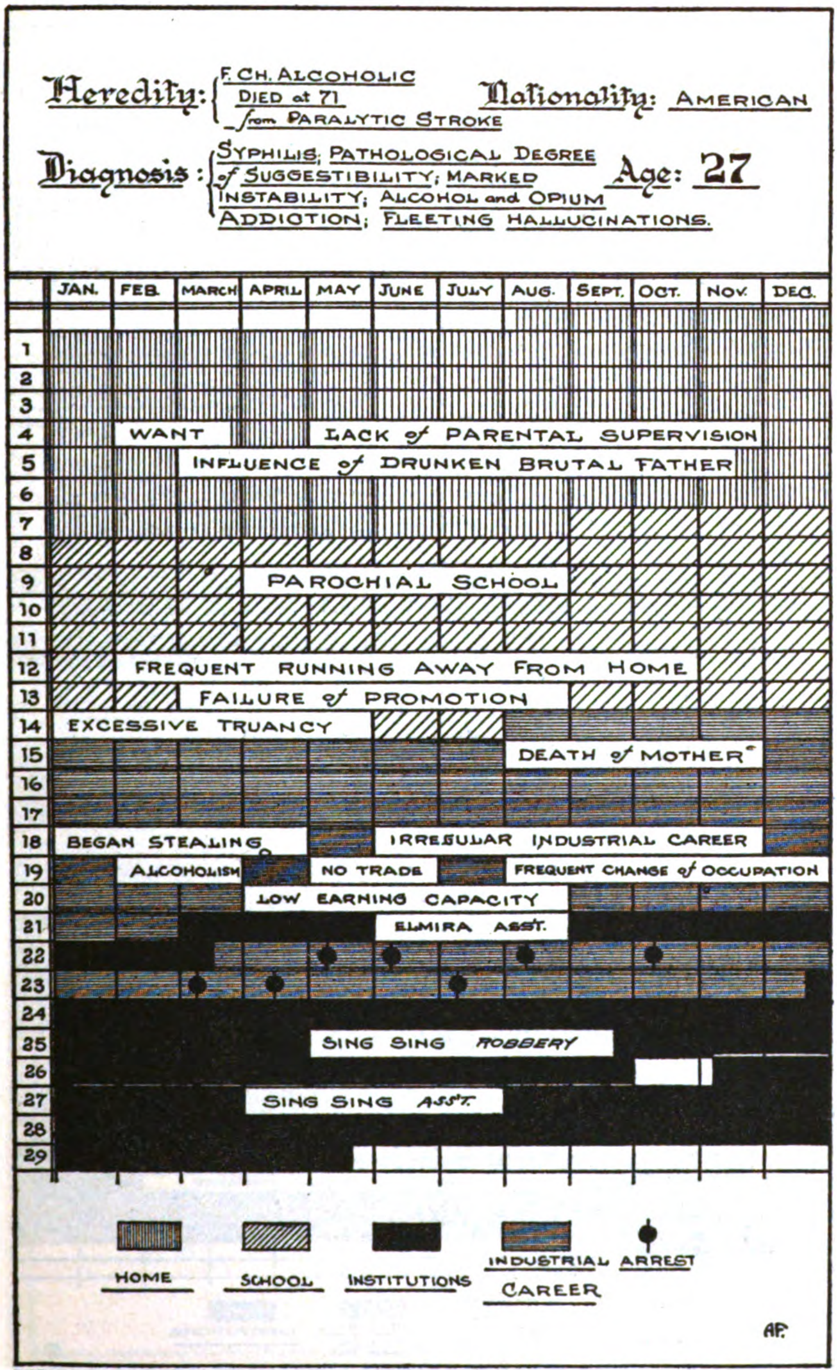
HOME
SCHOOL
INDUSTRIAL CAREER
INSTITUTIONS
AF.

trade of plumber, has been marked by gradual deterioration until he was finally content to take the position of porter in a saloon at $12 a week, whereas, in an earlier stage of his career as skilled mechanic, he was in the habit of earning easily twice that amount. His sex life has been very tempestuous, to say the least. Aside from a periodic tendency to promiscuous sex relationships, he has been married three times, the latest venture terminating in his arrest for bigamy. Neither of the two previous wives were divorced by him, but both had abandoned him for other men because of his failure to support them or otherwise to recognize his just obligations toward them. Neither bears a very good reputation. He has been infected with both gonorrhea and syphilis in the course of his unregulated sex associations, and at present betrays a total unconcern about his past behavior in this respect.

His addiction to alcohol was in the nature of habitual moderate indulgence with acute excesses, at which times he would become profoundly intoxicated, and would usually come in some sort of conflict with his surroundings. Of late years these prolonged sprees have become more frequent, and practically his entire earnings were spent for alcohol. His second marriage was consummated during a state of drunkenness. He states that he craves the saloon, to which he refers as "the poor man's club," for the sake of the company it affords him. It is significant of his waning powers of sociability, also noted by his mother, that while in early adolescence he was distinctly companionable and a good mixer, with plenty of friends, in later years his associations became increasingly restricted to the habitués of the saloon. He also gradually developed a roving spirit, and his mother states, "He had been all over the country."

A study of his personality at this date reveals a prematurely aged, poorly developed and undernourished individual, weighing 112 pounds on admission and showing active signs of syphilis and tuberculosis, which has necessitated his transfer to the hospital for the tuberculous. Intellectually he is still very well preserved, considering the excesses and corrosive experiences through which he has already passed. His mind is clear and alert, and his memory is not appreciably impaired. He shows, however, a distinctly pathological degree of euphoria, an illusion of well-being in view of his acute physical state. He also shows a fair degree of insight into his difficulties which he attributes to alcoholism, and while thoroughly conscious of the inroads this habit has made upon his will power, is not certain of his ability to overcome the appetite in the future. When imprisoned he seems happy, gregarious, a good mixer, and readily adjusts himself to the institutional routine. Certainly he seems to have very little capacity left for a keen emotional appreciation of the deprivations that go with imprisonment. In fact, one wonders whether he is not actually happiest under constraint and when removed from contact with the harmful influences of his mode of life at large. It is, indeed, not easy to lay down a definite course of procedure to be followed in his case, but the difficulty has been unduly aggravated by the mechanical, impersonal, unimaginative treatment to which he has been subjected in the past, and which can yield no better results in the future. Whatever promise of a future change in behavior still remains depends for its realization on the provision of a more flexible regimen of supervisory care and habit training than is practicable under a system of definite sentences within prison walls.

CHART 15


Heredity: F. CH. ALCOHOLIC DIED at 71 from PARALYTIC STROKE
Nationality: AMERICAN
Diagnosis: SYPHILIS; PATHOLOGICAL DEGREE of SUGGESTIBILITY; MARKED INSTABILITY; ALCOHOL and OPIUM ADDICTION; FLEETING HALLUCINATIONS.
Age: 27
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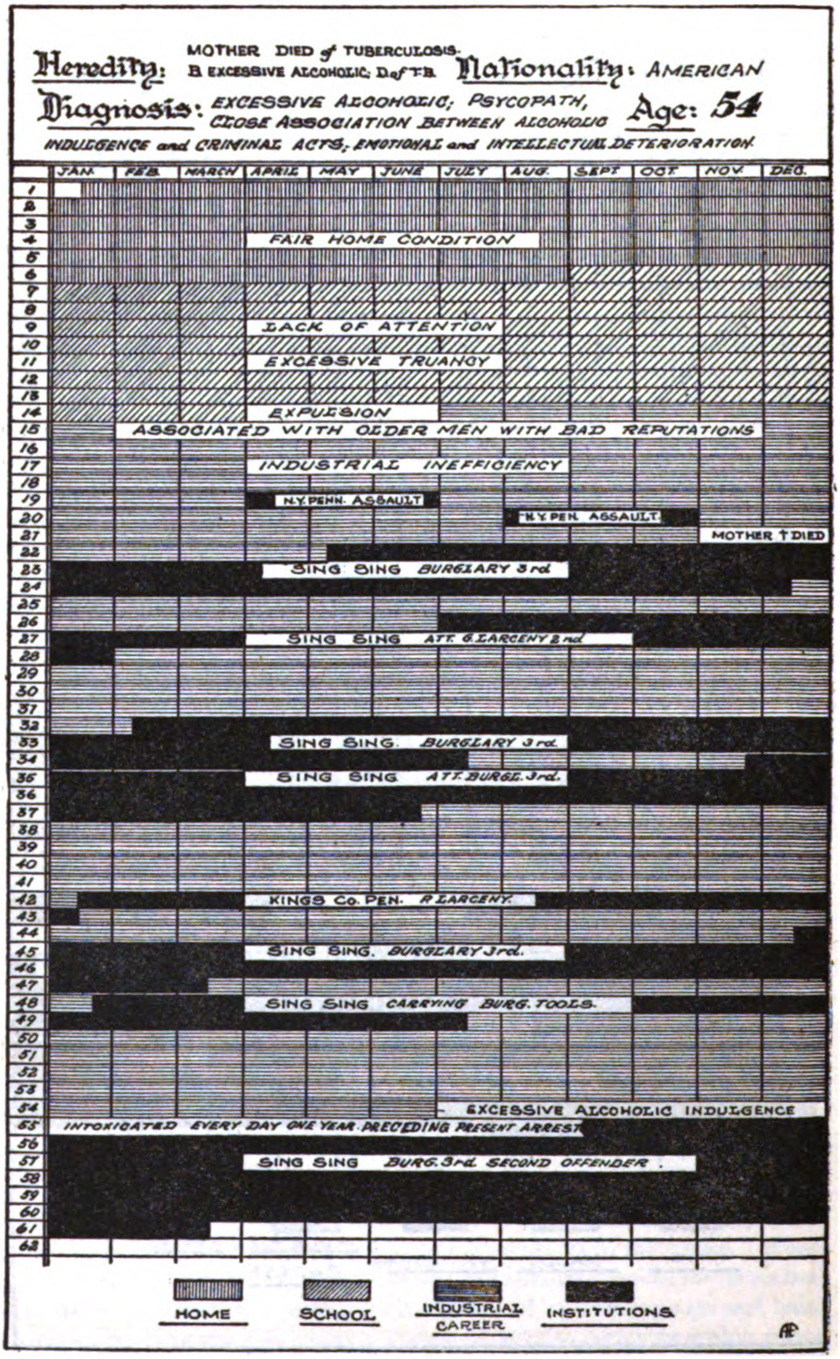
WANT
LACK of PARENTAL SUPERVISION
INFLUENCE of DRUNKEN BRUTAL FATHER
PAROCHIAL SCHOOL
FREQUENT RUNNING AWAY FROM HOME
FAILURE of PROMOTION
EXCESSIVE TRUANCY
DEATH of MOTHER
BEGAN STEALING
IRREGULAR INDUSTRIAL CAREER
ALCOHOLISM
NO TRADE
FREQUENT CHANGE of OCCUPATION
LOW EARNING CAPACITY
ELMIRA ASST.
SING SING ROBBERY
SING SING ASS'T.
HOME
SCHOOL
INSTITUTIONS
INDUSTRIAL CAREER
ARREST
AF.

CHART 16


Heredity: MOTHER DIED of TUBERCULOSIS.
B EXCESSIVE ALCOHOLIC; D of T.B.
Nationality: AMERICAN
Diagnosis: EXCESSIVE ALCOHOLIC; PSYCOPATH, CLOSE ASSOCIATION BETWEEN ALCOHOLIC INDULGENCE and CRIMINAL ACTS; EMOTIONAL and INTELLECTUAL DETERIORATION.
Age: 54
JAN. FEB. MARCH APRIL MAY JUNE JULY AUG. SEPT OCT. NOV. DEC.
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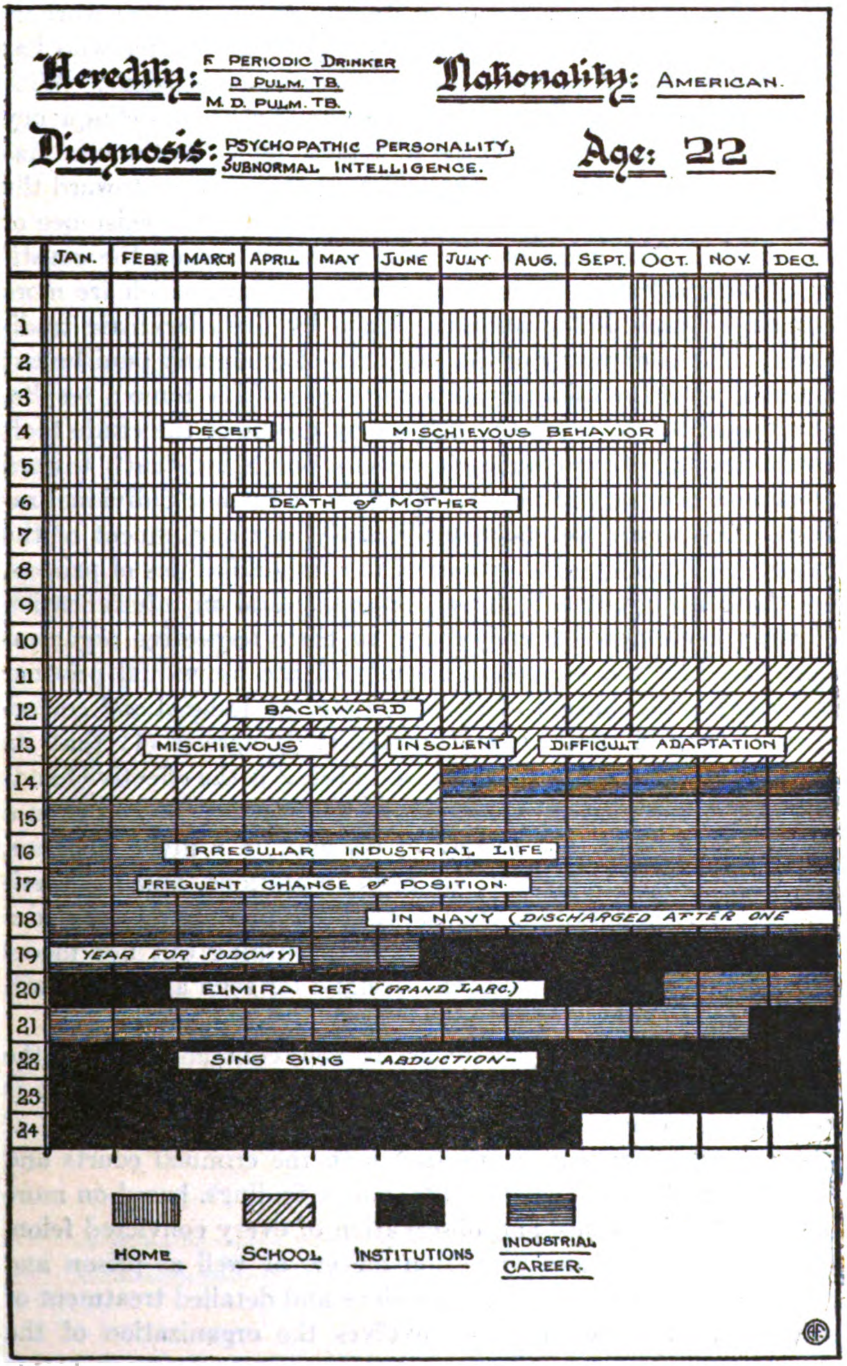
FAIR HOME CONDITION
LACK OF ATTENTION
EXCESSIVE TRUANCY
EXPULSION
ASSOCIATED WITH OLDER MEN WITH BAD REPUTATIONS
INDUSTRIAL INEFFICIENCY
N.Y. PENN. ASSAULT
N.Y. PEN. ASSAULT
MOTHER † DIED
SING SING BURGLARY 3rd
SING SING ATT. G. LARCENY 2nd
SING SING. BURGLARY 3rd.
SING SING ATT. BURGL. 3rd.
KINGS Co. PEN. P. LARCENY.
SING SING. BURGLARY 3rd.
SING SING CARRYING BURG. TOOLS.
EXCESSIVE ALCOHOLIC INDULGENCE
INTOXICATED EVERY DAY ONE YEAR PRECEDING PRESENT ARREST
SING SING BURG. 3rd. SECOND OFFENDER.
HOME
SCHOOL
INDUSTRIAL CAREER
INSTITUTIONS
AP

CHART 17


Heredity:
F PERIODIC DRINKER
D PULM. TB.
M. D. PULM. TB.
Nationality: AMERICAN.
Diagnosis: PSYCHOPATHIC PERSONALITY, SUBNORMAL INTELLIGENCE.
Age: 22
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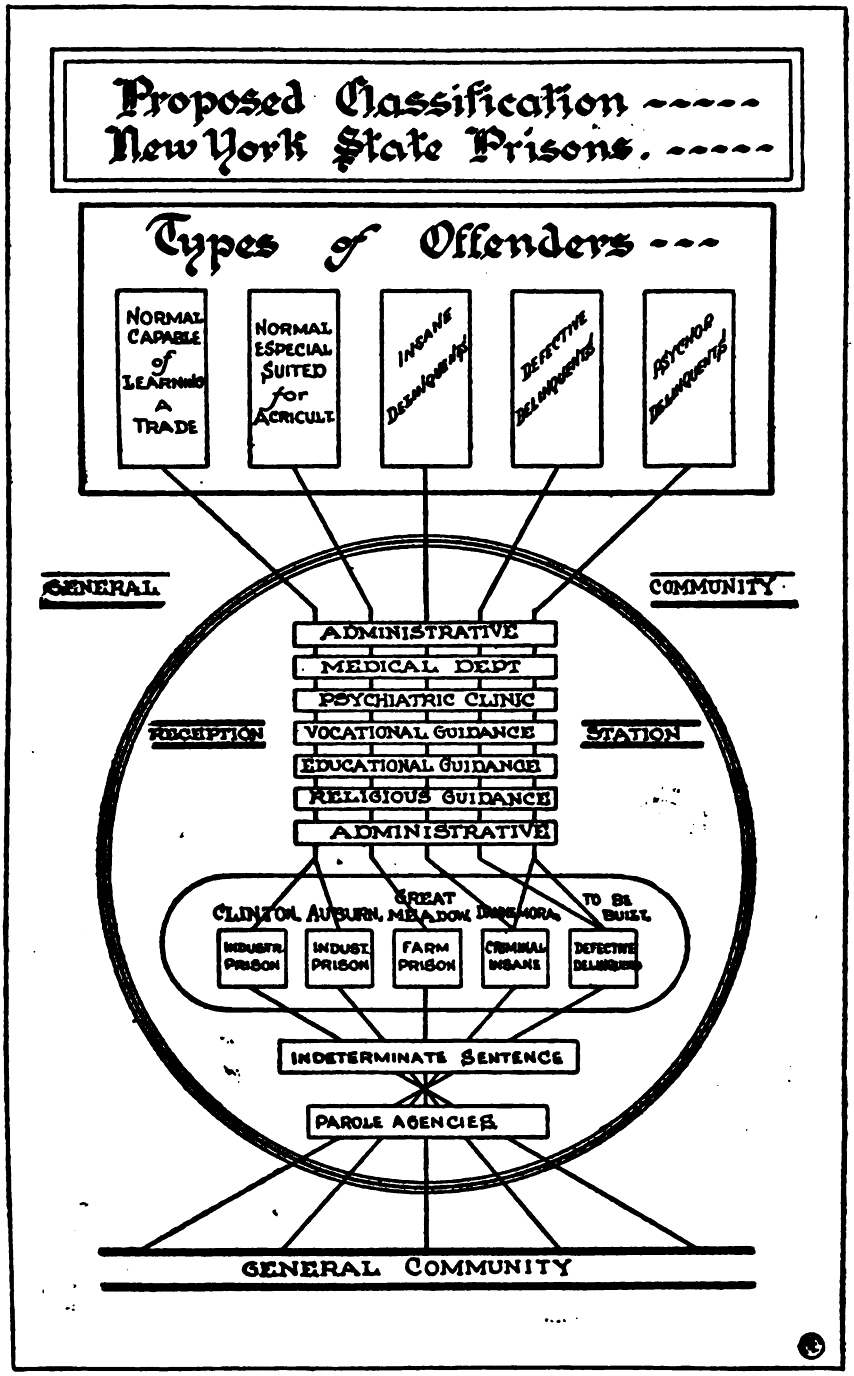
DECEIT
MISCHIEVOUS BEHAVIOR
DEATH of MOTHER
BACKWARD
MISCHIEVOUS
INSOLENT
DIFFICULT ADAPTATION
IRREGULAR INDUSTRIAL LIFE
FREQUENT CHANGE of POSITION.
IN NAVY (DISCHARGED AFTER ONE
YEAR FOR SODOMY)
ELMIRA REF. (GRAND LARC.)
SING SING -ABDUCTION-
HOME
SCHOOL
INSTITUTIONS
INDUSTRIAL CAREER.

In the light of the facts advanced in the foregoing pages, facts which find ample confirmation in the experience of other workers in this field, we feel justified in offering to the reader who has followed us to this point, a few constructive conclusions. With increasing understanding of the causes and nature of delinquency and insight into the possibilities of combating them, the need has become evident for a shift of emphasis in the attitude toward the problem, or in other words, for a recognition of the existence of a problem. This need is especially manifest among the constituted administrative agencies of the criminal law, which are more dominated than is the average citizen by fixed legalistic traditions. The complexity of the problems of crime and punishment together with the difficulty of achieving positive human results, as opposed to abstract legal justice, by means of the crude tools at the disposal of our courts and prisons, points insistently toward a revision of procedure in the direction of further individualization. This would not necessarily imply any abridgment of the powers and dignity of courts or of the responsibilities of prisons. On the contrary, it calls for an extension and an intensification of their usefulness by embodying in their respective organizations the function of scientific study of the individual prisoner and making this basic to the entire process—judicial and correctional. Once a progressive community is agreed (1) that its surest protection against the spread of crime is the effective handling of the criminal, (2) that such handling must proceed from a detailed knowledge not merely of his guilt in a given instance, but of himself, his history, his fixed limitations, and his possibilities for rehabilitation, and (3) that the test of efficiency in a modern penal system is its success in turning out not model prisoners, but decent citizens, the demand for such a program will become irresistible.

The concrete innovation which is now contended for as the most important step toward the realization of this program is twofold. It consists, first, in the establishment of a system of psychopathic clinics in connection with the criminal courts and the penal institutions of the state, whose findings, based on more or less intensive study and observation of every convicted felon, shall guide judges and probation officers as well as prison and parole administrators in their decisions and detailed treatment of such offenders. Secondly, it involves the organization of the prison curriculum toward the definite aim of turning out better

CHART 18


Proposed Classification -----
New York State Prisons. -----
Types of Offenders ---
Normal Capable of Learning a Trade
Normal Especial Suited for Agricult
Insane Delinquents
Defective Delinquents
Psychop Delinquents
General
Community
Reception
Station
Administrative
Medical Dept
Psychiatric Clinic
Vocational Guidance
Educational Guidance
Religious Guidance
Administrative
Clinton
Auburn
Great Meadow
Dannemora
To be built
Industr. Prison
Indust. Prison
Farm Prison
Criminal Insane
Defective Delinquents
Indeterminate Sentence
Parole Agencies
General Community

men from the institutions than had entered there. This can be accomplished most efficiently through the co-ordination of all those activities and efforts in our penal and reformatory institutions which have for their objects the training, reclamation, and general preparation for liberty of inmates, as distinguished from the material, non-human, strictly institutional management and maintenance. Without such organization the dominant consideration in the conduct of a prison system tends to be that of cheap and routine operation, with an inevitable tendency to sacrifice the real values and purposes, which are human and spiritual, to the incidental advantages of economy. With such organization created, however, and maintained at its highest level of efficiency by a trained criminologist at its head, the conditions would be provided for making New York State's prison system yield results in human salvage that shall be fully commensurate with the investment of money and skill represented.

Such centralizing and quickening of the various reformative agencies and facilities within our penal institutions is not only the next logical step in development, but it is necessarily implied in the project of a general receiving station and clearing house for the state which is now under construction and which is designed to replace the old Sing Sing Prison. The diagram on the preceding page (Chart 18), fully discussed elsewhere,* illustrates the contemplated co-ordination of the institutions and agencies concerned and indicates in a schematic way their differentiation of function within the entire system. At the clearing house all incoming prisoners would be subjected to careful examination and observation to determine their proper classification and corresponding course of treatment, discipline, etc., at the respective institutions to which they would be assigned. This treatment would be kept flexible and alert by a system of continuous records at each institution. At the clearing house, again, all inmates would be assembled prior to their discharge. With the aid of these records and on the basis of further study and field investigation, a reliable estimate could be reached as to the capacity for freedom and the further needs of each individual and corresponding recommendation made to the board of parole commissioners. On this solid foundation may then be inaugurated the administration of a truly indeterminate sentence and the way prepared for the eradication of habitual criminality with all that it entails.

* MENTAL HYGIENE, v. 1, p. 171–74, April 1917.

THE ADJUSTMENT OF THE JEW TO THE AMERICAN ENVIRONMENT*

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FOR years it has been maintained by the psychiatrical world that the Jewish race contributed more cases of insanity than any other race.† Of late years, however, some investigators in this field have begun to doubt this traditional view; they have found that it was not sufficiently demonstrated that the Jew differed in his liability to insanity from the Gentile, and some have gone so far as to assert that the truth lay in the converse of this view. This was also the conclusion reached a few years ago by the United States Department of Commerce which stated in its report: "On the contrary, facts from which deductions can be made point rather to a comparatively smaller amount of insanity among Jews than among people of several other races."

The first careful investigations were made by Sichel in Germany, who found that although there were relatively more Jewish inmates than the corresponding percentage of the Jewish population in Frankfurt, yet this could only be demonstrated in reference to certain groups of mental diseases, while the other groups revealed a smaller percentage than the non-Jewish population. Dr. George H. Kirby reached similar conclusions after examining the admissions to the Manhattan State Hospital from October 1, 1907, to September 30, 1908. He found only one Jewish case (and that very doubtful) among 182 cases of alcoholic insanity. The Jews represented the lowest figure in senile dementia and organic mental diseases. On the other hand it was found that the Hebrew race "*outnumbered enormously*" any race in the large group of the so-called functional psychoses, or those mental disorders in which the upsetting causes are psychogenetic factors. Dr. Kirby, therefore, concluded that the Jews do not contribute a disproportionate number of the insane.

* Read before the American Psychoanalytic Association, May 23, 1917.

† Insanity among Jews. By A. A. Brill and M. J. Karpas. *Medical Record*, v. 86, p. 576-78, October 3, 1914.

Some years ago Dr. M. J. Karpas and the writer investigated the same problem* and came to the same conclusion as did Dr. Kirby. From statistical data of the admissions to the Manhattan State Hospital, New York, for four consecutive years (1908-1912) we could demonstrate that the Jewish population of Manhattan and the Bronx contributed a higher percentage of insane patients only in regard to the functional forms of insanity. Without going into technical details it may be stated that by the functional forms of insanity is meant those mental disturbances which are due mainly to mental conflicts. Individuals evincing this type of reaction are very sensitive mentally; they are unable to yield to strong but prohibited desires or to give vent to mental injuries through retaliation or other ways. They suffer in silence and then repress the desire or the mental injury into the unconscious part of the mind.† Investigation shows that such repressions are not always successful, and that whenever they fail the result is either a mental or a nervous breakdown. It is from such forms of mental breakdown that the Jew suffers more than any other race. From a very large clinical experience I can state unequivocally that the same factors exist in the case of neuroses, the Jew is disproportionately neurotic. In brief it would seem that although the Jew is not disproportionately predisposed to insanity in the strict sense, he is more nervous than the non-Jew. In other words, the Jew is of a more sensitive make-up and hence adjustment to the environment is more difficult for him.

Belonging to a school which lays greater stress on the environment, though not unmindful of the part played by constitutional factors, I will be direct and state that the Jewish sensitiveness is largely, if not wholly, the result of his past environment. Any one versed in Jewish lore and history will readily realize the enormous amount of racial self-consciousness possessed by the Jews from time immemorial. This self-consciousness was imposed upon them by their conception of the anthropomorphic Jehovah who spoiled them with excessive love, and it was kept alive by the oppressions and inhuman treatment from which the Jews have suffered for centuries. The Jew was Jehovah's only and favorite child. The Bible refers to the Jews as the "chosen people," "the only son," and "the first born," and like the favorite child in life the Jews had to suffer for being favorites.

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* Insanity among Jews. By A. A. Brill and M. J. Karpas. *Medical Record*, v. 86, p. 576-78, October 3, 1914.

† The writer is well aware that the term "functional" is also used in a different sense.

In the writer's work on *The Only or Favorite Child** it was shown that being an only or favorite child is a disease in itself. The favorite child always finds it difficult to adjust himself to outside life because his bringing-up makes it hard for him to give and take emotions freely, and so the careful and loving rearing makes of him a poor competitor in the struggle for existence. The only or favorite child is usually coddled, spoiled, self-willed and egoistic, and because of his conflict with the inexorable world he usually develops into a neurotic, isolated being. It is interesting to note that the Bible tells us that the Jews were stiff-necked, spoiled and overbearing, and considered themselves superior to every other nation. Such characteristics have been attributed to the Jewish race by most writers of ancient and modern times, and even assuming that some of these statements are exaggerated it must nevertheless be admitted that they are essentially correct in reference to the Jews of antiquity and the modern orthodox Jew.

We also know that these statements no longer apply to the great bulk of western Jews who have enjoyed generations of freedom. Dr. M. Fishberg† explains this change by stating that "Judaism has been preserved throughout the long years of Israel's dispersion by two factors: its separative ritualism which prevented close and intimate contact with non-Jews, and the iron laws of Christian theocracies of Europe which encouraged and enforced isolation." That is to say, as long as the Jew has been imbued with the racial pride of belonging to the "chosen people," and has been offering daily prayers to Jehovah because he was not created a Gentile, he perforce remained exclusive and therefore was suspected and disliked by his non-Jewish neighbors. When we study the history of the Jews we find that their enforced isolation was the result of an early voluntary clannish exclusiveness. This shows the striking analogy to the only or favorite child who at first refuses to associate with others because he believes that he is superior to everybody else, and who is later excluded from social relations because he is misunderstood and disliked. Dr. Fishberg also tells us that as soon as the barriers are removed the Jews are readily assimilated and all former prejudices disappear. I find that the only child, too, loses his identity as soon as he realizes that he is not better than his fellow beings.

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* The Only or Favorite Child in Adult Life. By A. A. Brill. *New York State Journal of Medicine*, v. 12, p. 463–66, August 1912. See also Psychanalysis, Its Theories and Application. By A. A. Brill. 2d ed. Phil.: Saunders, 1914. Chapter XI.

† The Jews, a Study of Race and Environment. By Maurice Fishberg. N. Y.: Scribner, 1911. 578 p., illus. (Contemporary science series)

Bearing in mind the similarities of the abnormal traits between this Biblical only or favorite child and the only or favorite child of the present day, one clearly sees the reasons for preponderance of neurotic traits in the Jew.

When one examines the content of the conflicts causing mental and nervous upsets one finds that they invariably deal with the two great impulses, hunger and love in the broadest sense. Every neurosis or psychosis can be directly traced to some maladjustment in regard to the impulses of self-preservation and the preservation of the species, especially the latter. The difficulties encountered by the only or favorite child in adult life are plainly in the spheres of hunger and love. By virtue of his past he is a very poor competitor in the struggle for existence and his love life is glaringly poor. Natural selection which plays such an enormous rôle in the average individual is hardly visible in only or favorite children. Due to their abnormal attachment to their parents less than a fourth of the hundreds of cases I have seen selected mates, and most of these were unhappily married. For the same reason many of them marry cousins who resemble the parent in physiognomy and psychic traits.

Considering the adjustment of these impulses in the Jew it can be readily said that no nation has endured so many vicissitudes in the struggle for existence as the Jew, and no nation has found it so hard to earn an honest living as the bulk of the European orthodox Jews. As to the impulse of love, those who are acquainted with the life of orthodox Jews know that the word love in the western sense hardly exists among them. The orthodox Jewish religion is so rigid about sex that a normal love outlet is hardly possible, and the woman and everything that goes with her are under the severest religious taboos. Love in the service of the selection of a mate is a crime and cannot be tolerated by the orthodox Jew. And even the second generation of orthodox Jews who rebel against these restrictions and adopt the customs of their adopted countries still suffer from conflicts as a result.

In brief, we may say that both the only or favorite child and the orthodox Jew suffer from too many attachments of the past;

both are victims of circumstances, and both are neurotic as a result of the conflicts between the taboos of the past and the demands of the present. The only or favorite child is hampered in the stream of life because his early love life caused him to evolve into a clumsy and narrow-minded being, and the orthodox Jew, being stifled by taboos and inhibitions of the Mosaic and Rabbinic laws, is equally impeded in the free evolution of modern times.

The other factor in the production of neurotic traits in the Jew is of a later origin and is really a product of the first. In consequence of the harsh treatment to which the Jews have been subjected for centuries they came to be more or less suspicious and fearful of their neighbors and to rely only on themselves. Like the hermit who withdraws into an isolated existence on account of painful and disagreeable past experiences—real or imaginery—, the orthodox Jew, too, prefers to live alone because of the treatment that has been accorded to him from time immemorial. Originally he was forced to live in ghettos and in the pale, and now even where these restrictions no longer exist he surrounds himself with a spiritual ghetto. He is still restrained in his movements and is not a good "mixer." To be sure, Judaism is still more or less of a disability even in the land of the free.

As a result of this treatment the Jews evince a very strong *Familiensinn*. No race shows so much attachment to family and racial ties as the Jew. During my service in the State Hospital I was struck by the fact that the Jewish patients were visited more often and by more visitors than the other patients. My non-Jewish colleagues who did not understand the Jewish family spirit often found these visitors quite burdensome because of the peculiar emotional interest they manifested in their insane relatives. I am not stating anything new when I assert that the Jew has always been known and admired for his extreme love for his parents, family, and coreligionists. My own observation convinces me that the *Familiensinn* among Jews is so strong that it savors of the abnormal. So morbid an attachment to the family engenders narrow-mindedness. It signifies a blind attachment to the past and spells unprogressiveness. I feel that the bulk of orthodox European Jews demonstrate this relationship.

Now I do not wish to be misunderstood. I am not decrying normal family attachments, and I am well aware that even the slight exaggeration of it which one still sees among advanced westernized Jews has its great merits. A well-known business man has said that the secret of financial success in the Jew is not his capacity for making money but his ability to hold on to it. This he is able to do because his love for his family keeps him from reckless speculations. In a state of excitement the non-Jew often risks everything and not seldom loses. The Jewish financier is always conservative in his speculations because he never forgets his family, being attached to it by more than ordinary ties. But it must be remembered that excessive attachment to family is bad psychologically; progress consists in not following in one's parents' footsteps. This is why the Chinese are among the most backward people in the world. They still practice ancestor worship.

My feeling about the abnormal character of the Jewish family attachments was forced upon me by years of psychiatrical observation among Jews of all classes. Recently I was called in consultation by a non-Jewish colleague to see a very nervous young Jew. On our way my colleague, who was the family doctor, told me among other things, that the patient was one of five children (four sons and one daughter), that everyone in the family was very cultured, and that the love between the parents and children was "most ideal." He assured me that in his very large experience as a family physician he had never seen more ideal devotion than in this family. He said: "Their love for one another is so great that they care very little for the outside world. When one has a birthday all the others celebrate it by composing poems and musical compositions in his honor, and if one is ill they all become terribly depressed." My colleague did not exaggerate in his enthusiastic description of this remarkable family; but instead of sharing his enthusiasm I felt depressed. The obverse of the picture presented itself to me. I found that the young man was insane, that his sister had been insane, and all the other members of the family were very neurotic. This was an aristocratic Jewish family who possessed wealth and refinement, but who lacked the most essential thing in life, namely, the ability to make friends outside of their own narrow circle. They just lived for one another, they loved one another so much that they had no love left for any one else. I have seen many families similar to this one among all classes of Jews. And what is true of this family holds true to a degree of the whole race. It does not matter what the causes are, the Jewish people are more or less introverted, or turned into themselves, as it were, and this is the main factor in their neurotic character. No individual or race can live on itself, materially or spiritually. The Talmudic saying, "A pit cannot be filled from what has been taken out of it," is true psychologically. No person can remain healthy without constantly giving and taking emotions from the outside world. To be happy one must be able to put himself *en rapport* with many people. The orthodox Jew is precluded from such adjustment by his ancient heritage.

It may be argued that what is stated here no longer holds true for those Jews who have lived for some time in this country, and that as soon as the orthodox Jew will become emancipated he will learn to adjust himself to his non-Jewish neighbors and consequently his neurotic traits will disappear. This is essentially true. Freedom of environment undoubtedly begets free individuals, and as was said before there is a tangible distinction between the Jews of different countries. Still psychoanalytic study of individuals teaches that enormous forces have to be overcome during any transition from one psychological *milieu* to another. The sensitive Hebraic nature, formed through centuries, cannot be transformed into that of a well adjusted western individual without being subjected thereby to profound and even dangerous modifications.

With the little space at my disposal it would be impossible to show the play of forces which I have observed in the effort at the transformation of the Biblical Rabbinical Jew to the modern Jew. However, this much is certain—even in the most modern Jew one can observe the manifestations of maladjustment. Thus some of our wealthy cultured Jews are extremely sensitive about their Judaism. One can see how anxious they are to look and act like non-Jews and how they suffer from their Semitic past. They constantly evince their Jewish self-consciousness in their struggle to run away from everything that reminds them that they are Jews. They make desperate efforts to move in non-Jewish circles. They insist upon applying for admission to clubs and hotels where they are not welcome, and their unconscious flight often leads them to the extent of becoming strong anti-Semites. I have known a great many Jewish young men belonging to the second and third generation of American Jews who were very sensitive and very self-depreciating, and I could trace reactions to the fact that as children they were sent to non-Jewish schools where they were always referred to as Jews and treated as inferiors by both teachers and classmates. I have also seen a few sons of converted Jews who in spite of being born Christians were still struggling with Judaism. Most of them were self-conscious to a degree of paranoid delusions. It is a well recognized fact that most of the great Jewish bankers of today are more scrupulous and trustworthy in their transactions than non-Jewish bankers. Their emotional display is largely a reaction to the unconscious and conscious feelings of being suspected and mistrusted. It may be regarded as an over-compensation for the unscrupulous Jewish money lender of the past.

Such manifestations, of which I have mentioned only a few, are the results of the severe conflicts ensuing in the process of breaking away from a very dear past. The racial *Familiensinn* which represents to the Jew everything that is holy and precious is so powerful that only few great natures can tear themselves away from it. It is *aut Caesar aut nullus*. Orthodox Judaism allows no compromise. That accounts for the fact that so many Jews once they rebel against the old tenets throw off everything. Spinoza rebelled against his orthodox Judaism, and instead of the Hebraic anthropomorphic monotheism he formulated his pantheistic philosophy, instead of turning to the glories of the past he looked upon everything *sub specie aeternitatis*, under the guise of eternity. Berthold Auerbach, who made Spinoza the hero of a novel, was undoubtedly under Spinoza's influence and unconsciously imitated him when he rebelled and broke away from the past. In a recent article in the *New York Staats-Zeitung*, Altheimer, a friend of Auerbach, gives the latter's version of how he decided to give up writing about Jewish topics and instead to proclaim "the gospel of the eternal ideals of humanity." Auerbach related that after participating in the Yom Kippur (Day of Atonement) services in the Synagogue at Nordstetten, oppressed by the heavy and humid atmosphere, he went out into the open amidst the green mountains and the fresh air. He was strongly impressed by the great contrast, and to quote his words: "Now I saw my future before me. No longer: 'This house is my world,' but 'The world is my house.' No longer the past, but all life is as new as it is holy to me." He then and there resolved that henceforth "I shall write about *Land und Leute* which I have known and loved since childhood."

The same unbearable feeling of the old *Familiensinn* was experienced by Heinrich Marx, the father of Karl Marx, and Ferdinand Lasalle whose socialism undoubtedly was a reaction to the oppression of the Jews which he witnessed in his childhood.

History tells of many other Jews who, unable to stand the oppression of Judaism, rebelled and either embraced other religions, or, as was usually the case, formed new systems of philosophy in which they tried to reconcile Judaism with freedom. It is no accident that socialism was conceived and propagated by Jews, and that the ethical culture movement was founded by the son of a rabbi who was himself destined and educated for the same profession.

Very few Jews change their religion, and those who can overcome their enormous conflicts and embrace other creeds are usually huge failures as converts. A convert must perforce be a very religious person whose own religion no longer suffices to hold in check his tabooed wishes, and who in order to steady himself either seeks a new religion or a new minister in his religion who has the capacity of impressing him with greater authority and fear. The orthodox Jew has no need at all for the first though he sometimes rebels against his rabbi. With him it is a conflict between enormous inhibitions and freedom. He must go through a long period of transition before he can become, for example, a good Christian. The second, third or fourth generations of western Jews can make fairly good Christians. As a rule, however, even they are chary about unalloyed Christianity, and on their way thither they form little religions of their own, or, as is more often the case, they become Christian Scientists. This cult which is nothing but a flight from reality, a negation of one's trouble *par excellence* is eminently fit for the type of Jew who has struggles with his Judaism. As a Christian Scientist he is a Christian, yet not quite a Christian. His own neurotic conflicts are more or less absorbed by Christian Science so that he often obtains temporary relief, and his old Jewish commercial instinct can readily be appeased by becoming a healer. I have been struck by the large number of Jewish Christian Science healers.

Free Masonry which is a compromise between Judaism and Christianity is another religion which attracts many Jews.

These modes of reaction, namely, the transformation seen in the Jew of the Spinoza type and the gradual changes as seen among western Jews are not always effected. Not all Jewish youths can become philosophers when they rebel against their orthodox Judaism nor do they become members of other cults and movements. I refer particularly to the great number of Jewish children in New York and other large cities. The orthodox Judaism in which these children have been brought up is altogether incompatible with the radical tendencies of western culture. The Jewish boy brought to this country by orthodox parents, or those born here of such parents, cannot be kept long under the same restraint as in the old country. Their home atmosphere which is Russian, Polish, Galician or Roumanian, as the case may be, is so very different from the new and free environment in the streets or at school that the boy soon begins to be ashamed of his home and parents and tries hard to become an American in appearance and reaction. The struggle becomes very acute. The parental love and authority exert the strongest influence to keep him faithful to the old ideals, while his natural impulses yearn for freedom and new life. Psychology teaches that whenever two opposing psychic streams meet, a catastrophe is sure to result. Invariably the natural impulses triumph and the boy throws off all oppressing inhibitions and becomes an American. Here is where the danger lies. Sudden changes are often dangerous to the individual and to the environment. The Americans whom the East Side boy can take as models are not always the best persons to emulate. That accounts for the fact that so many Jewish boys go wrong. Once the parental authority is gone the old religion and all that goes with it disappear, and as the advanced culture has not yet taken deep root the emotions usually run riot. This process always causes enormous inner struggles and quite often results in a nervous breakdown. In my clinical experience with Jewish patients I have been deeply impressed with the fact that the conflicts at the basis of their neuroses very often deal with religion and parents. To illustrate I shall cite briefly two cases.

I have reported the case of a Russian Jewish young man who was obsessed with the idea that all Jews would be killed. This obsession clung to him for a long time and practically incapacitated him until he was cured. This patient was brought up on the East Side of New York City, and at the age of about five years he began to feel the burden of Judaism. One day while walking with his father, to whom he was greatly attached, he heard some of the Americans who loafed on the street corners call his father "Jew" and "Sheeny," which caused him much pain. Very soon, however, he felt ashamed of his father and would avoid walking with him in public whenever he could. This feeling persisted as he grew older and associated with "the boys," and caused him many conflicts. Analysis showed that his obsession that all Jews would be killed was a generalization of a repressed idea that his father should be killed. The latter not only represented his father but his God and his religion, in fact his whole Judaism.*

The other typical case was that of an elderly man who suffered from many neurotic symptoms. He had many obsessions and doubts with reference to religious matters. I soon discovered that he was a converted Jew and had been a Christian for many years, and that his inner struggles were between his old and his new religion. The surprising part was his inability to part with some of his synagogical paraphernalia which he kept secretly even after his conversion. A colleague told me of a very similar case.

The manifestations of some of these conflicts are ludicrous, to say the least. Thus I was recently invited to the home of an ardent Jewish Christian Scientist to participate in the Seder or the Passover Eve ceremonials.

The nervous breakdown is not the only issue of such conflicts. In many instances, especially where judgment is blunted by some mental deficiency, one finds that such boys and girls resort to all sorts of criminal practices.

I am well aware that not all Jewish boys of the type mentioned go through the mechanism described and that the great majority develop into good citizens. Still I feel that they all go through this great struggle, that a great many succumb in this conflict either in the form of a nervous or mental breakdown or in some criminal act. Almost all of them become alienated from their religion. They do not seem to realize that they can become thoroughly Americanized and still remain Jews, a feeling for which the uncompromising attitude of their parents is largely responsible.

One is at a loss to suggest any specific remedy for this difficult problem which I feel is of national importance. One feels that in miniature, it is the continuation of the old struggle between Orient and Occident, which might be left to solve itself in due time. However, much work has been done that has already borne rich fruit among those classes by social organizations. A gradual process of Americanization, or rather assimilation, suggests itself as the best method of approach at the present time. As this is impossible of accomplishment with most of the parents our greatest efforts should be directed toward the children. Our public school exerts an enormous influence in this direction. Jewish children love and idolize their school teachers. There are two reasons for this. The teacher occupies a peculiar position in every person's mind. During childhood the father is the highest authority in the home. He is omniscient and omnipotent. As children grow older the father gradually loses in estimation, and in time the children discover that he is just a human being; but as he seemed once a god they cannot forgive him for being an ordinary person and the tendency is to belittle him. It is at this period that the school teacher comes upon the scene and takes the place of the father; by virtue of his training he is able to make us look up to him as the great authority and we take the same attitude toward him that we once took toward our fathers. That accounts for the reverence in which teachers are held in general. It is not entirely due to their own merits, it comes from our subconsciousness. The second reason is more specific. The immigrant Jewish children, or those born of immigrants, live in two different environments. At home they are still Russian or Roumanian, as it were, while in the street they are in an entirely different world. As we said above, the child soon feels that his home is not as it should be. It is too foreign. He wants to be an American. His orthodox father, therefore, loses his prestige much earlier than is otherwise the case, and the only ideal left to him is his teacher at school who is not only the authority but often the only cultured American with whom the child comes in contact. It is impossible for the average person to realize the enormous influence the teacher exerts on the individual and especially on Jewish children. It is my opinion that the relatively large number of Jewish public school teachers in this city is mainly due to the unconscious idealization of the school teacher by his former pupils.* But the public school teacher's influence is often hampered by the orthodox Jewish teacher provided by the parents, who exerts his utmost to keep the child orthodox. As far as my observations go, he is always unsuccessful; the children usually dislike him, but there is no doubt that they retain many conflicting emotions as a result. It seems only logical that the orthodox teachers should be replaced by thoroughly Americanized Jewish ones who could harmonize Judaism with American ideals.

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* Those who are interested are referred to the full description of this instructive case. Psychanalysis, Its Theories and Application. By A. A. Brill. 2d ed. Phil.: Saunders, 1914. p. 102.

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* Those who doubt the importance of the influence of the teacher on his Jewish pupils are referred to the works of Myra Kelly.

Nor would conversion to Christianity solve the problem as some zealots seem to think. The normal Jew, like any other mentally sound person, always knows what religion he needs, while the mental defective behaves toward religion as he does toward anything else. A few years ago I was asked to examine a little girl of about ten years who was a sort of bone of contention between well-meaning Christian and Jewish ladies. The former had her converted to Christianity while the latter kidnapped her back to Judaism. This process continued for months and caused much ill feeling. The child was a low-grade imbecile. Only a gradual transition from eastern to western civilization intelligently guided by a sound mental and social hygiene, will prevent such abnormal reactions as neuroses, psychoses and criminality in the adjusting Jew.

A CITY SCHOOL DISTRICT AND ITS SUBNORMAL CHILDREN; WITH A DISCUSSION OF SOME SOCIAL PROBLEMS INVOLVED AND SUGGESTIONS FOR CONSTRUCTIVE WORK*

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IN the spring and summer of 1914, under the auspices of the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, a survey was made of the school population in the Locust Point district of Baltimore. Many school children had been brought to the Clinic for diagnosis and advice; they had come from all parts of the city and from outside Baltimore. How many such children existed in Baltimore, demanding study and special care, was unknown; it was not known how many of these children there were; it was not known how far the routine teaching in the ordinary school grades was a benefit or a detriment to them; it was not known to what extent they occupied the time and energy of the teachers to the disadvantage of the normal children; it was not known how far their neglect by the school system reacted on their behaviour at home, fostered bad habits and increased the disasters of their adult life. The survey of the special district was merely one step in the direction of getting information which an intelligent community can not afford to dispense with. The results of that survey have been published elsewhere in some detail.†

Of 1,281 children between the ages of six and sixteen, who were at school, 22 had so pronounced mental defect that they could never become self-supporting, 78 presented a degree of mental defect which undoubtedly required special school conditions, 66 with a lesser degree of mental defect would have benefited from suitable modification of the usual school environment. The general considerations suggested by these results have been discussed in the communication mentioned above; I propose in this paper to discuss in a less formal way some of the issues raised in the course of the survey, and the lines of further progress.

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* Being the substance of a lecture delivered, March 23, 1917, at the New York University in the special course on *Feeblemindedness and Society*.

† MENTAL HYGIENE, v. 1, p. 96-117, January 1917.

On the Methods of Determining Whether a Child Is Subnormal

In all situations where it is important for practical purposes to make a diagnosis the human mind craves some infallible test. Thus on one historical occasion a speech test was relied on as an infallible diagnostic criterion and whoever could not pronounce the word shibboleth satisfactorily was deemed an Ephraimite and was slain at the passage of the Jordan. The victorious men of Gilead probably worried very little over the fact that diagnostic mistakes may have occurred; the test gave much satisfaction because it was easy to apply, took up little time, and gave a clean-cut answer which did not require further thinking. In practical medicine there is a continuous hunt for such a shibboleth; the physician craves an infallible bedside sign or unequivocal laboratory test which will enable him definitely to recognize the underlying malady and apply the appropriate treatment.

A test of this sort is very elusive; it is usually found that it is not absolute and final and that even with the new test the physician still has to weigh a variety of factors. The more important the practical decision, the more useful such tests would be; and the extreme social and economic importance of the subnormal child makes us very anxious to have definite tests which will give us an absolutely conclusive answer. The question which we wish our tests to answer is whether the individual child has the stuff necessary for him to develop into a responsible and self-supporting adult; and if he is not able to become completely self-supporting, how far will his equipment carry him? Will he be able at least to do some simple remunerative work and get on well with his fellows, or is he condemned by his constitutional make-up to be almost wholly unproductive and socially unadaptable?

If the child can never become an independent adult, able to mingle with his fellows and responsible for the duties of the ordinary citizen, it would be foolish to give him training for adult civic functions.

It is evident that for many children with defective equipment the environment can not be that of the self-supporting citizen but will have to be modified; they will not be able to meet the ordinary demands of the labor market, the temptations of the social environment, the demands of the ordinary standards of morality. What sort of tasks can they undertake? With what environment will they have to deal? Will they live in the general community unsupervised or must they live in some sort of colony or institution?

If education is training for adult tasks, then the education of the future skilled or unskilled artisan will be different from the education of the individual who must always live safeguarded by the family or in an institution.

Education has long been limited to training of a very narrow kind, which has had little definite reference to the actual tasks of the adult; now that new conceptions are gaining ground, we see not only that education in general must have reference to the general tasks of the adult, but that no uniform system of training can be applied to all children, regardless of their make-up. The preliminary to any sane educational system would be the analysis of the material to be trained, and an estimate of the various groups of children to be educated.

Here the problem of grouping the children comes up and, in the survey of the district in Baltimore, the subnormal children were grouped according to their prospective adult efficiency into three groups, those who never could be independent, those of almost certain partial dependency, those of merely possible dependency.

It was not thought possible by the use of any one test or series of tests to be dogmatic as to the place of any individual child. Standard intelligence tests were given and extreme defect in reaction to these tests was considered strong evidence in favor of the child's general deficiency. Such intelligence tests, however, must be used in the setting of the whole clinical picture of the child; they have to be considered along with his emotional reactions, his adaptability to other children and adults, his output of energy (with the extremes of restless instability and dull inertia), his responsiveness to social standards, and in the light of his physical condition with symptoms perhaps curable (nutritional, glandular, neurological, etc.) or on the other hand indicative of constitutional peculiarity. In estimating the children in the district all these data were used, although of course in the most summary form.

I believe that in any provisional estimate of school material these factors have to be kept in view and that it is not safe to take any special intelligence tests as a final indication of the child's ability. Intelligence tests give us definite information as to the more marked degrees of constitutional inferiority; they are especially helpful in a homogeneous community and with a group of children of equal opportunities; they are apt to leave us in the lurch where we most require them, where we would like to have some means of determining whether the individual child will be able later to become an independent, self-supporting worker. A child of nine with "five years retardation," i.e., with a mental level by the Binet-Simon scale of four years, can not be expected to develop into an adult able to get along without assistance; but what about older children with five years retardation? What "mental level" must be attained if the individual is to be self-supporting? How far does it vary in different communities? Is it the same for urban and country communities, for North and South?

These questions we are hardly ready to answer; a few data from the Baltimore environment may be of interest. A consecutive series of fifty cases of backward children between the ages of fourteen and sixteen years, who applied for a special permit to work, was studied and followed for two years; these children had not passed the fifth grade, otherwise they would have been entitled to a permit. The average wage of these children at the end of two years was $6 a week; this no doubt may have been due to unusually favorable labor conditions (1916).

As to the mental level of the children, thirteen had a mental age of nine years when they applied for the permit in 1914, *i.e.*, they were at least "five years retarded." But two of these children, then "five years retarded," are at present attending night school; one of these two is making $7 a week as a factory worker, the other is making $8 a week as a huckster.

To forecast the future of such children one needs more than a figure denoting their intelligence level; one needs an estimate of the whole personality of the child (including information as to his heredity), some knowledge of the environmental influences, and some information as to the labor situation and the possibility of the individual's having some supervision. In other words the whole situation needs to be weighed in a common-sense way and the intelligence level of the child is merely one datum in the problem.

Thus I feel disinclined to give a definite forecast in the case of a seventeen-year-old boy, recently brought in from a reformatory school, with a "mental age" (Binet-Simon) of ten years. He had received little parental care, had attended school only at irregular intervals beginning at the age of twelve and did not go beyond the second grade. At fifteen his father on remarriage disposed of the boy by sending him to a reformatory school from which he ran away after one month. So far as we may judge from our experience, it is not unlikely that with fair training this seventeen-year-old boy may become self-supporting and stable, a law-abiding member of the community.

On the Importance of a School Survey to the Teacher and the Parent

During the course of the Locust Point survey the children were studied in co-operation with the teachers; a method which was of great mutual benefit both to the teachers and to the field workers. It placed valuable information at the disposal of the workers; it brought the point of view of the field worker, engaged in the wider problems of child welfare, to the attention of the teachers in relation to their own pupils rather than in an abstract form.

Such co-operation helps to bring before the teacher the broader issues of her work; she is stimulated to an interest not merely in the technique of imparting stock information to the children in her class, but to think about the personality of the children and the habits that they may be expected to form in view of their constitutional limitations. What habits can we expect these subnormal children to form? Have they the stuff which will enable them as adults to read and digest what they read, to have some knowledge of the past and to keep in touch with current trends of thought as expressed in the papers, to have some individual judgment and thus contribute something to the weight of public opinion, to enjoy the recreations which are available to others? If they have not the stuff necessary for this independent thought and action, how can their abilities be utilized so that they at the same time fit into the general commonwealth and get satisfaction in their own lives? This adjustment will only be possible when direction from without makes good the lack of direction within themselves; it must be brought to bear when the person is still plastic, when habits are being formed, during childhood; such guidance will not neglect the more fundamental habits, habits with regard to food, sleep and personal care; habits of neatness, punctuality and obedience; habits in reference to work, whether the work be the simplest household duties or more complicated manual occupation; habits of courtesy and mutual adaptation which may do much to oil the wheels in later life.

In this survey the field workers not only discussed the children with their teachers, but also interviewed the parents and tried to evaluate the home atmosphere. An explanation of much in the child was occasionally found in the alcoholism, mental defect or disorder of the parent, or in the fact of epileptic kin; a measure of the possibilities of the stock in its environment could be found in the parents' success or failure. The home visit procured data of great importance with regard to the child, such as conditions of nutrition, sleeping arrangements, home influence in the way of affection, encouragement, severity or repression, evidences of neurotic symptoms, peculiar moods or behaviour at home. In discussing these factors with the parent, much-needed insight into their importance for the welfare of the child was gained by the parent.

On the Extension of the School Influence into the Home through the Visiting Teacher or School Nurse

The study of the subnormal child leads one inevitably from the school to the home, and from the narrower pedagogic problems into the wider social problems. To understand the child the influences of the home must be studied. One may begin with the subnormal child; one is led step by step to study the whole situation from the standpoint of mental hygiene. Plans for helping the subnormal child blend with plans for raising the school standards, and for improving the hygiene of the home. The situation as it presents itself to the social worker may be exemplified by the following group of houses which are found in two adjacent streets. In these two streets are forty-four children between the ages of six and sixteen; sixteen of these children are sufficiently subnormal to require special attention on account of their poor mental equipment. These sixteen children are distributed in the ten homes to be enumerated.

1st Home: The home is untidy and dirty.

(1) Girl, 15½ yrs., 248 lbs., of low mentality, left school at an early age because of her ungainly size; she is lazy, gossipy and of lax morals; she works in a factory.

(2) Boy, 14 yrs., "mental age" (Binet-Simon) 10 yrs.; never got beyond the 3rd grade, an unreliable child.

(3) Boy, 10 yrs., "mental age" (Binet-Simon) 8 yrs.; is in the 2nd grade; he is deaf, has strabismus, suffers from eye-strain; has lax morals.

2nd Home: A maternal and a paternal aunt had epilepsy.

(4) Boy, 10 yrs., "mental age" (Binet-Simon) 8 yrs.; has been 2 years in the 1st grade; he is morose, stubborn, unreliable.

3rd Home: The mother works in a packing house; a son, 21, alcoholic from boyhood, has been several times in jail.

(5) Girl, 15 yrs., "mental age" (Binet-Simon) 9 yrs.; never got beyond the 3rd grade; is affectionate, industrious.

4th Home: Father alcoholic.

(6) Boy, 13, "mental age" (Binet-Simon) 13 yrs.; never got beyond the 3rd grade.

5th Home: Mother unable to read or write, but manages much real estate.

(7) Girl, 12, "mental age" (Binet-Simon) 10 yrs.; in ungraded class; morose, quarrelsome, intractable, with marked sexual interests.

6th Home: Father unemployed; mother working in packing house.

(8) Boy, 14 6/12, "mental age" (Binet-Simon) 10 yrs.; in ungraded class; steals, smokes, arrested for stealing $30.

(9) Boy, 11 8/12 yrs., in the 2nd grade; deaf, with defective speech.

(10) Boy, 9 5/12, "mental age" (Binet-Simon) 7 yrs.; two years in the 1st grade; defective speech.

7th Home: Father alcoholic, can neither read nor write.

(11) Boy, 12, "mental age" (Binet-Simon) 9 yrs.; shows choreiform movements; smokes.

8th Home: Father a laborer, mother works in packing house.

(12) Boy, 13 6/12, "mental age" (Binet-Simon) 10 yrs; is in ungraded class, never went beyond the 3rd grade.

(13) Girl, 10, "mental age" (Binet-Simon) 8 yrs.; eye-strain, headache, choreiform movements.

9th Home: Father of low mentality, mother alcoholic. One daughter is suspected of infanticide; one son is immoral.

(14) Boy, 14, "mental age" (Binet-Simon) 8 yrs.; in the ungraded class; morose, sullen, dishonest, untruthful, smokes.

(15) Girl, 11, "mental age" (Binet-Simon) 9 yrs.; 1½ years in the ungraded class, ½ year in the 2nd grade.

10th Home:

(16) Boy, 13, "mental age" (Binet-Simon) 9 yrs.; he dislikes school, smokes, is untruthful.

Consider these sixteen subnormal children in the light of the data available. They are born of poor stock and their congenital equipment puts definite limitations on what they can be trained to do, what they can learn, and how they can behave; they are poorly fed, ill clad, have no training in the simple habits of bodily care and cleanliness, their habits of sleep do not receive attention. The home atmosphere is often one of coarseness and immorality; their ideas of the relations of the sexes are tainted at the source. Their moods, their ability to get on with other children, their expenditure of energy, their ability to keep quiet for a limited time, their amenability to authority and discipline, are largely determined by their constitution. Society recognizes the importance of training these children from an early age; but having admitted so much, it is apt to consider its duty and interests satisfied by compelling these children to sit in school in groups of forty or fifty for rather long periods, and to derive satisfaction from instruction in abstract subjects such as grammar or arithmetic. It is too much to expect the few hours spent in the school atmosphere to counteract entirely the influence of the longer period spent at home and on the streets.

If it is important to take these special children in hand at an early age, the whole situation must be dealt with and the school must not be divorced from the home. While the problem must not be looked upon merely as one of school curriculum but as a wide problem involving the formation of good habits of bodily and mental hygiene, the school situation is undoubtedly the factor which society can most completely control. Compulsory education has been accepted by the community as a tolerable invasion of the rights of the individual, while individualism may protest against further encroachments and may tend to limit official influences strictly to the school period. It is right and proper, therefore, that on the school organization due stress should be laid, and that modification of the home environment should not be a disconnected activity but the continuous extension of the school influence; this will only come about if the function of education and of the school be widely conceived.

To make the situation more clear I should like to refer to a small class of subnormal children which is supervised by the Henry Phipps Psychiatric Clinic. Nearly all of these children had appeared in the juvenile court previous to their admission to this class; in the first year of their admission to the special class none of the children appeared in the juvenile court. Before they were in the special class, truancy was common; in the special class truancy disappeared, school was no longer a burden, it was a help and a privilege. The reason for the change was the fact that the children were now being educated in the true sense, that they were not merely memorizing abstract information, but were developing their native ability, utilizing their healthy interests, getting satisfaction out of helpful deeds and useful activities. These children began to form orderly habits, to care for their tools and material, to be tidy and cleanly, to turn out modest manual work, and from the articles of furniture made and flowers grown they derived pleasure and a feeling of self-respect, and were equipping themselves to be honest, if clumsy, workmen with fair social adaptability. But this was only looked upon as part of the directive influences radiating from the school; the home conditions of each child were investigated and, wherever conditions demanded modification in the interest of the child, they were attended to with the aid of the numerous agencies whose help could be enlisted.

The benefit of this method was not confined to the individual child, it involved the whole household. The co-operation of the parents was gained in almost every case; they showed a surprising amount of eagerness to learn to be of more use to their children. Unsolicited official advice as to hygiene, if coming from philanthropic organizations, may frequently be rejected in the homes of the ignorant, but where the advice is tendered by the teacher anxious for the welfare of the children it meets a gratifying reception. In the case of this special class the parents have come to discuss their children with the teacher, even after the children have left the special class. As we look over the records of this class we frequently see under the heading of academic work the note "very little progress," but lack of ornamental accomplishment is more than compensated for by seeing under the heading of general behaviour the still more frequent entry "steady improvement," which is made more specific by references to regular attendance at school, increased helpfulness at home, better standards of personal care, more intelligence in meeting practical situations, better relations with other children, and absence from the juvenile court.

In face, therefore, of such a nest as the ten homes above referred to, it is not necessary for us to be fatalistic nor to feel that we have to wait for some complex social reorganization to bring improved conditions into the homes. I believe that the best entry into that group of homes will be through the school system. Intelligent interest in the children will take the teacher or her representatives, the school nurse or the visiting teacher, into these homes, and they will be received there willingly because interest in the children is the only credential they need. They will bring help in the interest of the child, but help which will have a direct influence on the whole household; so, while helping the children through the parents we shall be helping the parents through the children.

The work previously outlined requires time and personnel; the teacher has at school often more than enough work to use up her daily stock of energy. It is still assumed that it is possible to educate children wholesale with no contact with their personality, and classes of forty or fifty are not yet unknown. Here the school nurse or visiting teacher may very well step in and, in co-operation with the teacher of the special class, take up the problem of the home influences of the child. A sufficient official personnel for the work may not at present be provided by the city or county, this may involve too heavy a financial burden, but it may be possible to utilize voluntary workers, so long as they are serious and get the necessary training. A sensible statement of the work to be done, with some guarantee for its supervision, may lead to financial assistance from private sources.

A healthy school atmosphere with intelligent training, combined with a tactful approach to the home situation, will give to the children sprung even from unfavourable soil the best opportunity of developing their modest abilities, of forming good habits of personal care, of work and of social intercourse, and of escaping the alternatives of dependency and delinquency.

On the Necessity of the School Nurse's and School Physician's Having Some Psychiatric Training, or Utilizing the Psychiatric Dispensary of the General Hospital

When the principles discussed have inevitably taken us into the homes of the subnormal children, we are face to face with the problem of the alcoholic father, the defective mother, the wayward brothers and sisters, the more difficult situation of marital incompatibility, etc. We are confronted with insufficient wages, with ignorance of how to spend money wisely, with ignorance of the simple laws of health, of dietary and cooking, with poor standards of cleanliness and comfort. We may find no suitable playground for the children; we may find gang influences; we may see at work the beginning of corrupting forces.

The worker coming from the school may look for some other co-operative agency which will deal with this hopeless tangle, and in despair may adopt a rather fatalistic attitude; the school worker may, it is true, find several societies in touch with the family, one looking after its lungs, another after its coal, a third after its paroled prisoner, but uniform direction seems lacking. However, if the school worker himself or herself have the necessary training or be able to call in the necessary technical help, the outlook becomes transformed.

The worker, whose psychiatric training has made him competent to deal with the problems of the subnormal child, has also in his work met the problem of the alcoholic father, of the wayward sister, of adolescent conflicts, of marked incompatibilities, of the influence on behavior of unfavorable environment. The home does not present problems belonging to an unfamiliar sphere to the nurse or physician with psychiatric experience; they are simply other examples of the same problems which have brought him there in the interests of the child. He now finds that he has not only a child to treat and train, but a home to deal with, a whole complicated situation to handle. This is the important conclusion; the adequate treatment of the child involves the treatment of the home situation. The treatment of the home situation is often not so hopeless as it looks; if we come to the task with adequate training, if one is not paralyzed by a fatalistic attitude, if one is determined to have modified whatever requires and is open to modification, whether it be the financial situation, the ignorance of domestic economy, alcoholism, or avoidable marital friction, then much may be attained, and starting from the problem of the child one may end in raising the level of the whole household. It may seem a large order; but there is probably in each community a large untapped reservoir of benevolence, and of willingness to help. This reserve force may require organization and training, but the individual worker drawn into the home from the school need not feel that all the work has to be done single-handed. Existing agencies can be utilized, they may be glad to have a greater definition given to their work, while in each city district, volunteer workers may be available whose good will might be capitalized and turned into productive channels. One, therefore, does not need to postpone action until the city has drawn up a comprehensive scheme with an adequate personnel, however desirable that might be; one can begin with the material that is available; one may elicit volunteer help, and do enough in a small way to show that he is engaged in a productive enterprise. The teacher if overburdened cannot, perhaps, go into the home; perhaps, as yet, her psychological training is inadequate. Her contact with the home will need to be supplemented by that of the school nurse or the special visiting teacher or social worker; the nurse will be all the more useful if her training has included mental nursing and some special study of mental hygiene. Her work should be guided by a school physician, but one whose training in mental disorders is adequate. As matters are at present, the nurse or school physician should be encouraged to utilize existing psychiatric clinics. It is eminently desirable that, whatever the organization be, one condition should be fulfilled, namely, that the study and training of the individual child should be carried on in the most intimate association with the study and treatment of the whole social environment.

If one result more than another stands out after a survey of the school population of a district, it is the intimate association of the school problems with the home problems, and there is no more hopeful avenue of approach to many of the extremely complicated social problems of today than through the school.

THE RETURNED DISABLED SOLDIERS OF CANADA

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WHEN disabled soldiers first began to return to Canada from the seat of war, the nature and magnitude of the task of providing for them was comprehended only by a very few people. The stream of returning men was at first small and it was generally assumed that, in most instances, the men would have received overseas all the active medical and surgical treatment needed and that, after passing through a period of rest and recuperation amid favorable surroundings and being equipped with any appliances that they might need, they would return to their homes. No one anticipated that the duration of the war would be what it has been or that so many men would be required. Time, however, has revealed that the returning disabled soldiers present a serious problem demanding for its solution, elaborate preparation, liberal facilities and good organization. The problem is found to be exceedingly complex, and to require an approach from medical, educational, social, economic, and political sides. A week's visit to Canada, made for the sole purpose of obtaining information concerning nervous and mental disorders among returning soldiers, scarcely qualifies me to discuss the general subject very intelligently, but what little I may have learned will I hope be of interest and possibly of service when the need arises. With Canada's experience to profit by, there could surely be no excuse if we were found unprepared when the stream of disabled and sick men from our army in Europe pours in.

The number of soldiers who have been invalided home to Canada since the beginning of the war is about 30,000. Of these about 11,000 are now in hospitals and sanatoria. The ports at which the returning men land are Quebec, Halifax, and St. John, and at each of these ports suitable accommodations are provided for their temporary care. A medical board is convened when a ship arrives, the condition of each man is determined, and his case is disposed of in accordance with his needs. A medical sheet or history accompanies each soldier in the army from the day of his first medical examination to his discharge, and this, together with his personal examination, determines the decision of the board. The arriving men are classified as follows:

(1) *Those for immediate discharge without pension.* Men who have been found unfit for overseas service but are capable of taking up their previous civilian occupations belong to this class, and also those whose disability is clearly not the result of service. The men of this class are given three months' pay with allowances, and are discharged.

(2) *Treatment cases.* These men are sent to hospitals.

(3) *Permanently disabled men for whom further treatment would be useless.* To these are given a pension, such appliances as they need, and training in an occupation if this be necessary.

For military purposes, Canada has been divided into thirteen districts. In distributing the men who require further attention, they are grouped geographically and each is sent to the district from which he entered the army. Most of the cases are sent to general military convalescent hospitals which have been established in the different districts by the Dominion Government. The policy has been to make provision for every type of case in each district. It has, however, been found advisable to depart from this policy for cases in which specialized forms of treatment are required. Three groups of cases are recognized as requiring special provision:—surgical operative cases, the tuberculous, and the nervous and mental cases. The surgical operative cases are, in most instances, sent to civilian general hospitals, the tuberculous to special sanatoria, and the mental cases to the Provincial hospitals for the civilian insane. Owing to criticism arising from the commitment of soldiers to the established institutions for the insane, the Canadian Government has recently opened at Newmarket, Ontario, a special hospital for mental disorders to which cases are sent without regard to residence. Another hospital for the treatment of the more aggravated forms of nervous disorders and of the more tractable and promising mental cases has been opened at Cobourg, Ontario. Cases are sent to this hospital under the same conditions as to Newmarket. The tuberculous cases are sent to special sanatoria, of which there are about twenty in the different districts, with a total capacity of about 1,200. Most of these sanatoria are public or private institutions for civilians which were taken over by the Government. The necessary additional accommodations were obtained by enlargements. The Government paid half the cost of these additions; the institution the other half, retaining full ownership. Many of the sanatoria are quite small, some being little more than private dwellings. Soldiers who are permanently incapacitated for self-support are sent either to their own homes or to a few small Government Homes which have been established for the purpose. One gets the impression in Canada that specialization in the form of special hospitals and in the organization of the general convalescent hospitals might, with advantage, be carried out much more fully than at present. The trend of progress seems to be in this direction. The need of a special hospital for venereal diseases was referred to by some of the medical officers, and it was thought that it would be established. At the same time it was stated that few active venereal cases were found among the returning soldiers, as they had usually been treated adequately overseas. There were, however, a great many cases with chronic conditions produced by venereal disease and these were frequently objectionable to the other inmates of the general hospitals. One of the medical officers consulted believed that a separate building for these cases at the general hospitals would meet the requirements. In Toronto, reference was also made to a proposed special hospital of 1,000 beds for all forms of nervous disorders, functional and organic, except the more protracted mental cases.

The large majority of the returning soldiers are sent to general convalescent hospitals of which there are in the different districts about fifty in all, with accommodations for about 8,000 patients. These hospitals vary in size from small private houses which accommodate ten or twelve to large institutions of 300 and 400 beds or more. The former are apparently residuals of the earlier development when the nature and magnitude of the task were not clearly appreciated. At that time the spacious homes of wealthy citizens were placed by the generous owners at the disposal of the Government and they were thought to be admirably suited for the purpose. It was soon found, however, that they were entirely inadequate, and now school and college buildings, hospitals for the insane and reformatories have been taken over at most of which extensive enlargements of light construction are found to be necessary. Preparations are being made for 1,200 or 1,500 beds in some places, and the provision which seems to be most approved by the medical officers is for large, well-equipped, general hospitals organized with reference to the special needs of the various types of cases requiring treatment, and for some highly specialized hospitals for such forms of disease as tuberculosis and nervous disorders. A good example is found at Whitby, Ontario, where a new hospital for the insane which had not yet been occupied was given over for general hospital purposes. It is expected that accommodations will be provided there for 1,200 or 1,500 patients. The number accommodated at present is 400. Provision was being made for surgical operating, hydrotherapy, electrotherapy, massage, dentistry, X-ray and violet-ray, physical exercises and games, occupations including carpentry, cement work, motor mechanics, shoe repairing, basketry and agriculture. Similar provision was found in operation or planned for in some other hospitals visited. The medical organization at Whitby consists of a medical officer who specializes on chests, two in general medicine, two in surgery, one of whom was an orthopedist, one in diseases of the eye, ear, throat and nose, and one in neurology and psychiatry. The provision for treatment outlined at the special hospitals for nervous and mental cases was similar to that at the general hospitals, though the medical organization was different, since the hospitals were smaller and the work more specialized.

The transportation of the men from the ports of landing to the hospitals is made in ordinary sleeping cars for those who are fit, and in specially equipped hospital cars for the others. The hospital cars are operated in pairs. One, called a composite car, contains quarters for medical officers and nurses in addition to cots for eight patients; the other, called a ward car, has accommodations for fourteen patients. The entrances to the hospital cars are at the side so as to facilitate the handling of patients on stretchers. A pair of hospital cars may be attached to a passenger train, or a number of pairs may be made up into a special train. Upon arrival at the hospital, the men who are well enough are given ten days' leave of absence to visit their friends. During this period they wear a special uniform so as to be easily identified in case, as sometimes happens, they fail to return in time. Each man received at a hospital is given a careful examination, including a routine Wassermann test, an inventory is made of his needs and disabilities, and a program of treatment, with re-education when necessary, arranged for him. In the larger centres of population, one hospital is used as a clearing station, and from this the cases are distributed in accordance with their needs and the room available. Nearly every type of case, except the more severe forms of mental disorders, may, however, be found in all the general hospitals.

The management of the hospitals and sanatoria for returned disabled soldiers is not under the control of the War Department, but is vested in a civilian Military Hospitals Commission which was established by an act of Parliament soon after the war began. This was before the task to be undertaken was fully understood, and it is now considered a mistake.* The soldiers did not react well to civilian control, and it became necessary to bring military officers into the hospital to maintain discipline and secure co-operation in the treatment. A dual system has resulted which is not entirely satisfactory. A further complication has grown out of the provision in the Canadian constitution which leaves to each province complete control and management of its educational system. Under this provision it was believed that the education of a disabled soldier in a new occupation would have to be provided for and controlled by the provincial governments. Experience has shown, however, that the only satisfactory plan for the management of the hospitals and re-education work is to make them a part of the military system. All except a very small percentage of the men at the convalescent hospitals are ambulant cases. The period of rest, recuperation and mothering which was at first thought to be all that would be needed has been found, on the contrary, to be highly detrimental. The soldiers do best when kept under strict military and medical direction and control during the whole period of treatment and training. They object to receiving orders from civilians. Most of them are mentally and nervously reduced as the result of hardships and strain, and it is easy for them to drift into chronic invalidism and idleness. They have also, while in the army, become accustomed to following a fixed routine and acting on orders only, and their initiative has been to some extent impaired. Many of them are under the impression that they have done so much for their country that they should be supported for the rest of their lives by the Government, and in this they are not infrequently encouraged by well-meaning sentimentalists. Objections have been raised even to asking the soldiers to do any of the household work at the hospitals, unless they volunteer. The men invariably desire to get home as soon as possible and their friends are anxious to have them. If this is permitted before all has been accomplished for them that is medically and educationally possible, many who could be restored to productive occupations will remain incapable and dependent. Both military officers and civilians who had observed the returned soldiers were agreed that every effort should be made to maintain the energies of the disabled soldier and to stimulate his ambition to be restored to productive citizenship. In the best hospitals, therefore, a spirit of activity is maintained. Physical training is compulsory, and a schedule of occupation, recreation, and retraining, if necessary, is carried out for all the patients. The better appearance and spirit of the men in these hospitals were quite apparent.

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* Since this paper was written announcement has been made that the Dominion Government has created a new department under a responsible minister of the crown. Senator Sir James Lougheed, who has been head of the Military Hospitals Commission since its inception, will be in charge of the new department and will have full cabinet rank. The name of the department is to be the Soldiers Civil Reestablishment Department. The Military Hospitals Commission with its staff is to be continued under the name of the Invalided Soldiers Commission. The new department and the Invalided Soldiers Commission will work in close co-operation with the various provincial governments. The medical end of the work is to be under the control of the Canadian Army Medical Corps.

Although in some of the convalescent hospitals, provision is made for surgical operations, it has thus far been found possible to have the more important work of this kind done at the civilian general hospitals. Little information was obtained relating to the surgical operations required. It was learned, however, that a large proportion of the cases of severed nerves which had been hastily operated upon at the front required secondary operations. Reference was also made to cases of osteomyelitis and to dental reconstruction work. Amputation cases are kept in the hospital until they can be fitted with artificial limbs. In Toronto, these cases and those requiring orthopedic attention are sent to a special hospital in connection with which an artificial limb factory is operated. The methods employed for restoring the function of crippled and paralyzed limbs are quite interesting and ingenious. Very simple and rather crude looking apparatus is employed for exercising the limbs and for measuring improvement. This apparatus consists of a variety of devices by means of which any of the joints from the digits to the hip can be exercised against resistance and a record made of the result. The exercises are so arranged that an appeal can be made to the man's sporting instinct, and he is encouraged to beat his own record. This is found to be quite effective. Massage, electricity and various forms of baths are also employed in the treatment of these cases, together with general physical exercises and games. At Hart House, of the University of Toronto, under the direction of Professor Bott, a psychologist, instruction and training are given in the use of apparatus and of other forms of physical exercise employed in the reconstruction work. Many of the soldiers from the hospitals in the neighborhood come to Hart House for treatment.

One of the great difficulties in the Canadian hospitals has been the lack of a sufficient number of trained workers in the special forms of treatment such as massage, hydrotherapy, electricity, therapeutic and vocational occupations and physical exercises. This difficulty has been, in some measure, met by intensive short courses of training. Many of those who have taken these courses and are now employed, belong to the Voluntary Aid Detachment of the St. John's Ambulance Association, a British organization which performs some of the work undertaken in this country by the Red Cross. The members of this organization do not, as a rule, receive any compensation. They pay for their training, in some instances for as long a time as seven months, buy their own uniforms, and pay their own expenses. About 1,200 of them have gone overseas, where they are employed as nurse aids, cooks, ambulance drivers and in other capacities. The expenses of those in service overseas are, as a rule, paid by the organization, and their uniforms are furnished by the Canadian Red Cross. Each receives also a cash allowance of ten dollars a month. One hears much of the V. A. D.'s as they are called, and their services are evidently much appreciated. They are to be seen in the hospitals where they do light orderly work, probationer's duties, assist in the laboratories, drug departments, and offices, give massage, electrical and hydriatic treatment, and aid in the occupational work of the patients. They appear to be women of unusual intelligence and refinement, and I was informed that the young women from the best families in Canada had volunteered for this service.

The occupational and educational work which is carried on at the convalescent hospitals has for its central purpose the physical, social, and mental occupation of the men with a view to promoting their recovery. Definite training in a new occupation, to replace that in which the soldier was formerly engaged and for which he has been unfitted by reason of military service, is theoretically not begun until after his discharge from the army. Practically, however, the occupational work in the hospitals in many instances is definitely directed toward fitting the man to earn his living. Instruction in common school subjects is provided so that a man may improve his general education. Preparatory courses for civil service examinations, and courses in stenography, bookkeeping, and office work are also offered. For those who are contemplating mechanical pursuits, instruction is given in handicrafts, mechanical drawing and practical mathematics, and for those who intend to take up farming or gardening, there are courses in agriculture, poultry raising, etc. As far as possible the men are encouraged to choose the occupation in which they will be trained. A vocational counsellor is, however, provided for them, and a board consisting of the vocational counsellor, a medical officer, and a layman, who may be an employer or labor organizer, passes on each case. Many of the men incline towards occupations for which they are not fitted, and others would fail to see opportunities which an intelligent counsellor is able to point out to them. Some of the men will, in their future life, occupy positions much better than those which they were able to fill before they entered the military service. The more definite training in a new occupation is taken up after discharge from the army. This method is not recommended by the Canadians, but has been made necessary by constitutional provisions relating to the responsibility of the provinces for education. The expense, however, is borne by the Dominion Government, which also pays to the soldier during the period of training an allowance, in addition to his pension, and an allowance to his family. These allowances are diminished as the man's earning capacity increases. The shops of the technical schools and colleges are utilized for training purposes, and to some extent commercial shops are also used. The latter are found, however, to be less satisfactory than those conducted by the Government, as it is difficult to secure the systematic training and instruction needed. Even in regard to this training and the selection of an occupation, the soldiers respond best to advice and supervision under a military officer, and vocational advisers are as far as possible appointed from among men who have served at the front. It even makes a difference as to whether an officer has been "over the top" or not. Some who have for one reason or another been sent home without going farther than England are frequently referred to by the soldiers as "Safety First" men, and others who are known to have been merely taken through the front trenches as visitors are called "Cook's Tour" men.

The lessons which Canadian experience seems to teach may be summarized as follows:

(1) The inadvisability of subjecting to the hardships and strain of life at the front men who are not physically and mentally fit, inasmuch as they soon become an encumbrance and an expense.

(2) The necessity of preparing well in advance for the needs of the returning soldiers.

(3) The necessity of increasing greatly in some organized way the number of persons available for applying special forms of treatment, even though the training given may be of too short duration to be thorough.

(4) The advisability of maintaining military control over returned soldiers until they have been restored to as high a degree of capability as possible, and have been trained in a new occupation whenever this is necessary.

(5) The necessity for large, well-equipped and well-organized military convalescent and reconstructive hospitals.

(6) The advisability of doing everything possible to encourage the returning soldiers to look forward to their return to an active and useful life, and to avoid everything that suggests a diminished responsibility, a lower degree of efficiency, or dependency.

BARRIERS TO THE TREATMENT OF MENTAL PATIENTS

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BARRIERS to the treatment of mental patients exist in the nature of mental disease and its disabilities, but they have been erected far beyond the necessary height, or created without necessity, through misconception, tradition, inadequacy of methods and provision for treatment and care of such afflicted, and, especially, through stringent forms of legal procedure in attempting to safeguard personal liberty and property rights.

Those ancient fallacies as to manifestation of the malign influence of evil spirits in persons "distempered in mind," and as to the rôle in this connection of witchcraft, the moon and other mysterious agencies, have been dissipated in the light of advancing knowledge of mental disease; yet it is not long since lunatic, lunatic asylum and lunacy commission were the accepted terms in legal and state nomenclature, and even now are thoughtlessly used, sometimes, by the well informed in these matters. In a few states these terms still continue in legal and legislative usage.

Clearer conception and definition appeared in the later terms, insane, insane hospital and board of insanity, but the original meaning of these soon became clouded by association with legal formalities and restraint, so that the stigma of mental incapacity and deprivation of personal liberty became inseparable from them. It is an old and true saying that "a rose by any other name would smell as sweet." Indeed, any denotation will eventually acquire a significance expressive of actuality. Nevertheless, a new designation of an old content has this advantage. It is free of traditions based on false conceptions, abuses long corrected, and prejudice fixed by inheritance. The new name starts with a lightened legacy from the past and gathers a meaning expressing truer concepts and worthier practice, if real progress is being made.

Furthermore, the field of psychiatry has broadened, reaching out from the confines of institutional interests and needs into the community at large where it touches the mental patient in incipient stages of disease, in his family, social and industrial relationships, and aspires to prevent as well as cure and alleviate mental illness. This wider range must find expression.

There is a growing tendency to greater frankness between the physician and his patient in mental, as well as general, medicine, which merits encouragement. Official terms must be used in explaining to the patient many conditions and situations. They confront him in inscriptions upon tablets on hospital walls, in printed rules and regulations which he must observe, on letterheads used in correspondence with his relatives and friends, in legal notices which must be read to or by him, and in numerous other unavoidable ways. The phrases "lunacy law" and "commission on lunacy" are printed in bold type in a notice required to be "posted in a conspicuous place on every ward of every" mental hospital in Pennsylvania. They are read by every patient of sufficient mentality, and he feels himself thereby stigmatized as a lunatic. Nevertheless, such uses of official terms, in the main, are wise and unavoidable. Therefore, how imperative it is that they express true concepts in acceptable phraseology with least suggestion of reproach and discouragement! Should they not emphasize the hospital idea, the patient ill with disease having a physical basis, amenable to prevention, cure, or amelioration? Would it not be conservative to propose mental patient, hospital for mental and nervous diseases, or, in the case of the public institution, simply State Hospital and its location without specifying its character? Might not State Board for Mental Hygiene comprehend the preventive and communal duties as well as the institutional relations of the general supervisory board?

The urgency of treatment for mental patients is not always sufficiently appreciated. The first question put is not always, Where is the most accessible provision for this purpose? but instead, Where does he belong? To which poor district is he chargeable? What is his financial ability, or is he a pauper? These are important questions which must have satisfactory answers, but ought they ever to be allowed to delay treatment? Are they matters for court decision *before* commitment? May they not properly wait until suitable care has been afforded the patient? Prolonged investigation may be necessary, involving great difficulty and delay. Meanwhile the patient may be neglected at home, or oftentimes, in the police station or jail. Moreover, there is grave doubt whether an investigation of this sort is best pursued before a busy court; whether expert knowledge possessed only by the State Board, or its trained agents, is not required. There is experience in some states confirming belief in the greater efficiency of an expert support agency under the control of the general supervisory board.

Probably the outstanding consideration in public estimation relates to the financial aspect of this great problem. Rarely do those untouched by actual contact, personal or collateral, with this sad malady fail to subordinate the humane and medical needs to the cost requirement. Pauperization is among the original sins against the mental patient, which has bound him in association with the real pauper and delinquent. In early days all these classes, with other dependents, came together for refuge in the poor house in the poor district under the poor authorities. Their separation is a natural evolution of inherent differences in their needs and measures suitable to their relief. The effacement of this barrier, insuperable to the early treatment of mental disease, would best be promoted by complete severance of the connection of all mental patients with poor house, poor district and poor authorities under state care and support.

There is a common fallacy that mental disease and mental defect may be ignored with impunity; that the apparent saving by scanty provision for care of such afflicted is good public economy. In consequence there is no virile and insistent public demand upon the legislature, or councils, to make sufficient appropriations. The overcrowding of all public institutions for these patients is deplorable and universal. The proper classification and treatment of patients are thereby rendered impossible, their safety jeopardized and complaints of abuses multiplied. There eventuates in the community even graver consequences. These needy mental patients are crowded back into poor families, whose burden is well-nigh unbearable, the patients themselves denied treatment, the welfare of neighbors endangered, the future menaced in likelihood of reproduction in kind. A still darker hue appears in the spirit of gloom and hopelessness pervading the whole situation. Some doubt whether it is worth while to attempt a struggle against so overwhelming a tide. After all, does it bear anything save a mass of human wreckage which in mercy should be allowed to pass as swiftly as decency may cast a veil? Such pessimism is unworthy and without justification. Not long ago the same clouds obscured the vision with discouragement over the ravages of infectious diseases and tuberculosis.

The outlook for mental disease and mental defect is no less encouraging, nor is it limited in possibilities to the compass of actual achievement in those fields. But our philosophy must be recast. So long as this matter remains a problem of *poor relief*, mere buttressing against a rising flood without thought of *the sources* of the waters, so long will continue the present submergence under an increasing accumulation of end-products and mental wreckage. Primarily this problem presents a medical aspect and appeals to the leadership of medical men. It comes within the field of public health and should constitute a co-ordinate department in its activities. Its imperative requirements are prevention by investigation and removal of causes; hospital facilities for the best treatment and adequate curative effort; provision for early diagnosis and treatment, both through the family physician who has been afforded sufficient psychiatric teaching in his medical course, and through community agencies organized to minister to the needs of mental patients in their homes or to guide them to appropriate sources of relief; occupational training and re-education as measures of treatment; resourceful and persistent endeavor to alleviate and improve chronic mental conditions, thereby reducing the amount of care and its cost.

This order would evolve and, I believe, is evolving out of educational influences which are gradually creating in the public mind the conviction that initiative and adequate performance in the field of mental hygiene is well worth while; that mental factors in community problems must be eliminated as a necessary preliminary to their solution; that their causative relation to dependency, delinquency, inebriety, industrial inefficiency and anti-social tendencies is important and disquieting; that the mental patient left in the poor family without treatment, a hamper to the bread winner and a constant strain upon the whole household, is much more costly, both in immediate outlay and the potentiality of increased future expenditure, than when cared for in a suitable public institution; that it is not only humane but true public economy to seek out all these and encourage their early treatment and care on the plan above outlined.

To this evolution certain obstacles are present in this commonwealth. [Pennsylvania]* There is lack of unity of responsibility for its promotion. State, county and municipality, each has authority to do as much as may seem expedient; but none feels the obligation to do more, however deficient may be the effort and sum total of accommodation for the care of mental patients. Each waits for the other to act. The driving force of public opinion and need is spent between them.

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* The conditions here enumerated are not peculiar to Pennsylvania. They obtain in other states.—EDITOR.

There is another source of division of responsibility, in that a board of trustees of a state hospital has power to refuse admission of patients beyond the capacity of the institution. Hence, accountability for overcrowding with its attendant dangers and difficulties rests upon the institution. Its trustees have no alternative other than protection of its patients by exercise of this power of exclusion. It is not effective because the sympathy of the trustees and their appreciation of the needs of patients and the urgency of public relief always constrain them to the limit of their conscience in stretching the capacity of the hospital. Overcrowding always exists. It breaks the force of appeal to the legislature because it opens an avenue of evasion of full responsibility for relief. The visiting committee of the legislature, knowing the trustees possess this power of self-protection, complacently leave the matter to their adjustment. Realization of the disastrous consequences both to hospital and community is slight because the rejected patients are scattered far and wide at large; whereas gathered in crowded wards their wants would be obvious and their appeal forceful. While the intent of this provision of law is beneficent, its effect is harmful and conducive to increase the evil whose correction was sought. In other states, where reception of patients is compulsory, relative insufficiency of accommodation is less, and overcrowding of patients in institutions not greater.

The first requisite, then, in a constructive policy would be concentration of powers and responsibility in the proper unit of authority. The scope and complexity of requirements point to the state as the only logical agency adequate to meet them. Should any municipality, or county, desire to continue performance of such duties, so be it as long as they are performed satisfactorily, but let the state shoulder the remainder of the burden and supervise effectively all subordinate agencies. Care and support of all mental dependents, as they appear in the future, should be assumed by the state in its own institutions.

A state board, representing the commonwealth in so large and important functions, would necessarily be an independent body analogous to the State Board of Health with powers no less extensive and organization no less adequate to progressive and efficient service.

Its leadership should inaugurate, with the support of private agencies, an educational movement enlightening the public as to the nature and causes of mental disease and mental defect, the measures for their prevention, the necessity of early diagnosis and treatment, and the adverse consequences of neglect.

Immediately would appear the need of bureaus of information and direction to appropriate agencies of assistance, centers for preliminary medical examination and diagnostic tests, social service with supervision of mental patients in families, their after-care when discharged from hospitals, their temporary care and treatment pending admission or commitment to institutions; in short, the need of *community mental clinics* and out-patient departments of general and special hospitals.

Another outcome would be the discovery of many mental patients in the community and the great deficiency of provision for them in institutions. The definite and practicable plan for meeting these needs in a progressive and economical manner should be formulated by the State Board after mature investigation through its expert agents in co-operation with institutional trustees and superintendents, private agencies and individuals of special experience. Such plan should be comprehensive, providing through scientific research for acquisition of new knowledge of mental abnormality, adequate preventive effort, hospital facilities for the best curative treatment of patients, their humane care and the amelioration of their condition by occupational and re-educational measures. This plan should be capable of extention into a co-ordinated state system of activities, responsive to the growing demands of progress. The leadership of the State Board should win recognition and public support and furnish the sustained energy necessary to a continuous drive toward the achievement of its aims. A paramount duty in this direction would be the insistent presentation, at stated intervals, to the public, the governor and legislature, of the full requirements of its policy with the cogent reasons back of them without qualification from motives of expediency. The pressure of circumstance and conflict with other projects will always militate against favorable action by the government. The opportune time to satisfy the full needs of mental patients will never come without a struggle. While a fair apportionment of funds must always be cheerfully accepted by their friends, the arm of opposition should never be strengthened by initial concessions without uncompromising insistence upon their full needs and rights.

The mental hospital, like the general hospital in its early development, is commonly regarded by prospective patients and their friends as the last resort after failure of every other recourse. The legal and judicial mind rarely conceives it as other than a place of incarceration justified only by the menace to individual or public safety or the impossibility of home care. The concept of its beneficent ministration to the mind diseased as any physical part of the human body is just appearing in shadowy outline in public consciousness. The effacement of this barrier to early treatment is slowly but steadily progressing. Its pace will be hastened if every mental hospital continues to become, as speedily as may be, the real hospital in the broadest sense, with emphasis laid upon its treatment function and subordination of its control relation within the reasonable limit of caution. The mental hospital and the general hospital are essentially alike. Mental factors predominate in the former, but are potent influences in the latter. The difference is one of degree only. All the imperative requirements of the one must be met by the other. They are supplementary agencies in curing and alleviating disease and must be, eventually, viewed in the same light and administered in the same spirit on even planes of humaneness and efficiency. Their separation in space and management may be convenient and desirable under particular circumstances, but judicious planning may obviate all the difficulties of their intimate association. Indeed, there is doubt whether any general hospital system in a large community is complete without its psychiatric unit of distinct identity in organization, special facilities and equipment. This psychiatric unit should be limited in size and restricted in function to observation, diagnosis, short curative treatment, scientific research and teaching. The long resident mental patient should pass on, as a rule, to the hospital and colony in the country under the same management.

Many mental patients are conscious of illness long before they, or their friends, suspect mental derangement. Treatment in a suitable hospital would be sought or, at least, accepted early if the suggestion of mental affection should be avoided. Should such patient be persuaded to enter a mental hospital, he usually feels the shock of abrupt contact with a large group of varied personalities showing unmistakable symptoms of mental disorder. The voluntary relation of the patient to the hospital is likely to be broken forthwith. Hence, too great stress cannot be laid upon the importance of initial classification of mental patients. Every mental hospital should have a reception unit, apart or convenient to the main department, in which separation of new patients may be made in small, harmonious groups.

Furthermore, the admission of voluntary patients would be greatly encouraged if every mental hospital could have a small unit, at a suitable distance from the reception unit, for preliminary observation, diagnosis and treatment of incipient and borderline mental patients under the voluntary relation where none of the obvious and distressing manifestations of mental derangement would be seen. The thought of being in a nervous sanatorium without needing to pass beyond into the mental hospital itself, would be a great solace and satisfaction to such patients.

Gradually in these ways the beneficence of the mental hospital to its patients is being revealed and is receiving popular recognition in their growing confidence and use. But the greatest barrier to the rational treatment of mental patients still stands rockfast in legal, and even medical, insistence upon stringent forms of court procedure which may obstruct admission to mental hospitals. Obvious is the necessity of safeguarding against violation of personal liberty and property rights of persons rendered by mental abnormality incapable of self protection; also against persecution of physicians and others whenever question arises as to purity of their motives in assisting to procure necessary restraint of such persons; but always must be borne in mind the fact that mental abnormality is not an entity, definite and uniform, whose disposal may conform to an unvarying formula. Outside the boundary of legal insanity, defined by infringement of law, actual or potential, there is a wide range of mental and nervous conditions which present only humane and medical aspects. The practical definition of this line of distinction requires evaluation of the individual and pertinent circumstances in every instance.

Precedence of humane and medical needs may be conceded, and legal requirements suspended for a limited period, during which the patient may receive shelter and suitable treatment pending necessary formalities of law, whenever injury would result otherwise to the patient or others. It is gratifying to find precedent for the necessity and safety of such suspension in a humane provision of the Pennsylvania law of 1883, section 38, the first provision of the kind in any state, so far as I know, which suspends operation of the penalties of the act for forty-eight hours, during which a mental patient may, for his own or another's welfare without improper motive, be received and detained in a mental hospital without first meeting legal requirements for commitment. This temporary care in a mental hospital is important, because it affords immediate aid to the mental patient who cannot be kept at home and who might otherwise be detained for a considerable length of time during delay in legal proceedings at a police station, an almshouse, or some other receptacle, where adequate medical attention would not be available, at a critical stage in his illness. It may be noted that there is, and *should be*, no authorization for apprehension and forcible conveyance of the patient to the hospital. Objection by him or another must be heeded until proper authority be procured. The reception of such patient should be safeguarded by requiring the certificate of a physician, duly qualified as an examiner in mental diseases, that he needs treatment because of mental or nervous affection. The duration of temporary care should be limited to the reasonable period, probably not exceeding ten days, necessary for observing forms of admission and commitment, or arranging discharge to the care of relatives or friends. It may be of interest to add that a similar temporary care act has been in operation in Massachusetts since 1909 with general satisfaction.

There is another large class of mental patients whose hospital treatment requires no intervention of law. The mental patient who desires such treatment and is mentally competent to decide may properly be received into a mental hospital upon his own written request for admission without other formality save notification to the State Board and his friends. Should he change his mind, he should give written notice of his intention or desire to leave the hospital and should not be detained thereafter against his will beyond a reasonable limit, probably not exceeding five days, necessary to arrange with his friends for care elsewhere or, in case the welfare of himself or others may require, for his legal commitment. The support of such dependent should be governed by the same provisions of law as apply to the support of a committed patient, inasmuch as an attack of mental disease may be thereby prevented, or its severity mitigated.

Temporary care and the voluntary relation, encouraged to the limit of their possibilities, would obviate legal intervention in hospital treatment of many mental patients, but there would remain a residuum whose objection to hospital admission could not be overcome by persuasive measures. Whenever objection is made, either by the patient or another in his behalf, strict observance of law must be maintained in commitment or other forcible disposition of mental patients. In such cases the following situations may arise.

1. An escaped patient under lawful commitment as insane in another state may be found in this commonwealth in which there is no legal mechanism for returning him to the state where he belongs prior to commission of violent or criminal acts. Extradition between states should be possible in such case.

2. Dangerous insanity may be manifest in a person who evades every attempt at medical examination. The judge of a court of record should have power to authorize his apprehension and examination for determination of insanity under such limitations as to duration and conditions of care as the judge may direct.

3. Dangerous insanity may escape detection by single or repeated examination without continuous observation in a mental hospital. The judge of a court of record after hearing such evidence as he may deem sufficient, should have power to commit, under such limitations as he may prescribe, such case of doubtful insanity to a mental hospital on the certificate of two duly qualified physicians that his mental condition is such that his commitment is necessary for his proper care and observation pending the determination of insanity.

4. Emergency by reason of dangerous tendencies, violence or other causes, may necessitate immediate, forcible conveyance of an insane person to a mental hospital when the delay of full commitment would be injurious to him or others. A certificate of insanity by two duly qualified physicians should be sufficient to authorize his conveyance, reception and detention in a mental hospital for a limited period not exceeding ten days, with requirement under penalty of suitable fine, that the applicant should complete the commitment or procure discharge of the patient within such period.

5. Involuntary commitment of a mental patient for indefinite treatment in a mental hospital should be duly authorized with substantially the following requirements:

a. Application to the judge of a court of record by some relative, near friend or other suitable person, who should be required to furnish the usual statement of particulars in the case.

b. Certificate of insanity and need of hospital treatment by at least two duly qualified physicians under suitable limitations as to character, time, place and other conditions of examination of the alleged insane person.

c. Order of commitment by the judge of a court of record after examination of the medical certificate, hearing other evidence of insanity, and such further investigation as the judge may deem necessary.

There should be right of appeal to a jury.

Such commitment should not be part of regular court proceedings but a special matter for attention at any time and place appointed by the judge.

Records of commitment should constitute a private docket in the custody of the judge to be transmitted by him to his successor without becoming public records necessitating publicity of private affairs of the patient and his relatives.

Appearance of the patient in court should be avoided whenever possible within the discretion of the judge.

In conclusion, such legal barriers seem to be necessary safeguards at the present time, but the consequent delay in the treatment of mental patients may be minimized by enlightened application and gradual extention of humane provisions of law until mental disease assumes the same character in public estimation as other types of illness.

VOCATIONAL REHABILITATION OF SOLDIERS SUFFERING FROM NERVOUS DISEASES*

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IT was not unreasonable to have expected that many men in the armies would be unable to stand the mental strain imposed on them. Hardly anyone, however, was prepared to find such great numbers of men so disabled by neurasthenia alone that they must needs be discharged from the army. In England nearly 20 per cent of the 175,000 pensioners are suffering from functional nervous disease and the greater part of these have not been actually wounded. In Canada, over 10 per cent of all the 25,000 men who had returned up to October 1, 1917, were classified as mental cases. This category included insanity, shell shock, neurasthenia, etc. If those who were returned as overage, underage, and for duty are excluded the mental cases represent 15 per cent of the invalids, and if those suffering from actual wounds are not counted, the mental cases constitute 25 per cent of all those returned from the Canadian army in England and France.

From a purely military point of view this factor of war neurosis is highly important where so many men have to be discarded from mental causes. From an economic standpoint, the treatment of so large a percentage of invalids in order to reinstate them in productive work is a serious matter. This exceptional phase of the war has been met with the same thorough consideration, consummate skill, and hopeful progress as the other phases of medical organization.

In the early period of this struggle the men showing evidences of neurasthenia and allied disorders were removed far from the front lines and even sent to England, where no special institutions were in existence for their treatment. They were cared for at first in the general military hospitals, but the alarming increase in the number of these cases led to their segregation and special methods of treatment by the spring of 1915. When the German submarines began to sink hospital ships as well as all other kinds of tonnage, a great deal of the medical service was, perforce, carried out in France. From the experience gained, the British and French were led to take care of the neurotic cases nearer the lines. Neurological centres are now established in the immediate rear of the trenches out of range of all except the heaviest guns. A special Shell Shock Hospital is run in conjunction with a Clearing Hospital in each army area. Each individual soldier is looked upon as a separate case. He is carefully interviewed, diagnosed and classified. The main thing is to find out the personal matter that troubles each man. The doctors, nurses, and staff are all carefully selected for their special abilities and personalities. The atmosphere of the institution is a deliberately planned mixture of firmness and kindness. It has a military tang, but is not so impersonal and severe as the army. All of the staff are expected to radiate optimism and cheerfulness. The patients are kept as far as possible from introspection, the worm that feeds upon sick nerves and tends to make them sicker. Quick recoveries are the rule and a high percentage of the men return to the trenches inside of a month or even within a fortnight. An expert French medical officer in charge of one of these centres reports that 91 per cent of the cases received in a four-month period were sufficiently recovered to send back into the fighting line. This is a highly important achievement from a military point of view in keeping up the strength of the battalions. Regimental officers have been given printed instructions to the effect that they should themselves aid in helping men whose nerves are temporarily jarred by encouraging remarks at the right moment. For fear that there might be some malingering in this direction the medical officers now classify men as suffering from neurosis "A" and "B" instead of neurasthenia and "shell shock" the symptoms of which had become all too familiar with the common soldiers.

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* Read at Annual Conference of the Massachusetts Society for Mental Hygiene, Boston, January 9, 1918.

If the patients do not show signs of quick recovery they are sent to the base or to England. If they are Canadians and will not be fit again within six months they are sent home for further treatment before discharge. When they arrive in Canada, at Halifax or Quebec, they pass before a standing medical board, which has the accumulated experience from handling thousands of cases.

If the men are suffering from a form of mental disease that treatment will not benefit, they are sent to the hospital for the insane in the province to which they belong. The government pays for their maintenance and if the man is married, his wife gets the same pension for herself and her children as if her husband were dead.

If the case is severe and needs more careful diagnosis and treatment, the man is sent to the Central Hospital for Nervous Diseases at Cobourg, Ontario. This is delightfully situated in rural surroundings and is under the direction of trained specialists. From here, patients may be discharged to hospitals for the insane, to regular convalescent homes, or to civil life.

If the case of neurasthenia is mild, the man is sent to the regular convalescent home nearest to his own home. There is not much that he can get in the way of diet or medicine to improve his condition so that he is often made an out-patient and allowed to live with his friends or family.

The men at the Cobourg Hospital at one time do not represent the average type of cases which are treated there.

Captain C. B. Farrar gives an analysis of the patients as of February 1, 1917.*

	Cases	*Per cent*
Fairly definite types of dementia praecox	17	34
Psychopathic inferiority, morons, etc.	6	12
Defectives belonging to above two groups	4	8
Dementia paralytica	6	12
Shell shock or trench neurosis	6	12
Other neurotic reactions	3	6
Alcohol as dominant factor	2	4
Manic reaction	2	4
Depressive reaction	1	2
Epilepsy	1	2
Trephine epileptoid	1	2
Paranoid	1	2
	50	100

Captain H. A. McKay, the Medical Officer in charge of Cobourg, states that in December, 1917, the cases were classified as follows:

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* War and Neurosis, *American Journal of Insanity*, 73: 696, April 1917.

	Cases	*Per cent*
Insane	15	20
Shell shock	11	14
Crucial epileptic	1	1
Mentally defective	5	7
Moron	1	1
Dementia praecox	8	11
Nervous instability	9	12
Hypo-mania	3	4
Delusional insanity	3	4
Melancholia	5	7
Epilepsy	3	4
Stupor	2	3
Dementia	3	4
Confusional insanity	6	8
	75	100

Hydrotherapy and electrotherapy are used with most gratifying results, but some form of vocational training is depended upon to build up the will and initiative of the patient. If he is allowed to spend most of his time idle, or if he is given too many consultations and much involved treatment, he will have continuous opportunity for his mind to dwell on his disability and is in danger of becoming a confirmed neurasthenic. He must be given some light occupational work so that his interest will be aroused and his mind kept from instrospection. His initiative and confidence in himself must be awakened. He is first told that his nervous disability does not at all unfit him for success in some civilian occupation, but that it is severe enough to debar him from any further military service. This sets his mind at rest about being returned to the army and directs his attention toward the future. He is then given some light occupation such as basketry, clay modelling, etc. At first he works only an hour or two but this is gradually increased until he is working all day. Then he is graduated into classes where more diligence and effort is required, such as the carpentry, gardening, or pottery class. The men are praised judiciously for satisfactory performance, but the officials are always firm and do not "mollycoddle" the patients or sentimentally sympathize with them. After the men show a live interest in the vocational work the doctors do not pay much attention to the medical massage treatment so that the mind of the patient is almost entirely concerned with other things than his own condition. The vocational training in the institution at Cobourg should be classed as occupational therapy because there is not the serious industrial motive underlying it that exists in vocational re-education. When the patient is fit to return to civil life he goes back to his old job or enters a course in another institution or else is apprenticed in industry to gain the knowledge and skill necessary for his success in some regular occupation.

By far the greatest number of shell-shock and neurasthenic cases go to regular convalescent homes. Their disabilities vary from the man who is highly nervous and cannot give sustained attention to any one thing to the man whose head continuously waggles or has continuous tremors, or stutters so badly that he has to write his expressions. It must be clearly recognized that practically all of the returned soldiers are mentally abnormal as compared with their condition before enlistment. For months or, perhaps, years they have had to repress their individualities and sink them in the army machine. Their severe drill and discipline has bereft them of part of their initiative because they have been taught to obey without question or argument. They have had little thought for their food and raiment; these were chiefly the concern of others. They have had practically no worry about the maintenance and well-being of their families. Except for certain periods of supreme effort and uncomfortable conditions of living, they have found military life easier than the hard grind of the life which they left behind them. Death has lurked at their elbow night and day in so many terrifying forms that they have come to think little and lightly of the morrow.

After the glorious comradeship of the trenches, the grim excitement of the charge, the explosion of bombs and shells, the high tension atmosphere of the front, civilian life appears casual and safe, but cruel and cold. To break down the habits that have been formed by the iron will and mailed hand of the army is more difficult than to instil them. It is harder to demobilize than to mobilize. To give the returned soldier the power for continuous attention to the humdrum tasks of peace conditions; to make him react truly to inspirations generated from within himself; to regenerate his initiative; to drag him away from the condition of depending on external stimuli for thought, amusement, and action—these are the difficult tasks set for those who are responsible for preparing him to shed his uniform.

The end to be accomplished is even more difficult with the returned neurasthenic than with the average case in the convalescent homes. As a layman who knows nothing about medicine, it seems to me as though it would be better to segregate the distinctly nervous cases in institutions away from their own homes. The man suffering from shell shock without any wound or disease receives little sympathy from most of his comrades. If he is especially jumpy or nervous, some practical joker is very likely to throw a piece of crockery or an electric light bulb to smash with consequent distressing results. Then again, when made an outpatient and permitted to live at home or among friends, much maudlin and misdirected sympathy is showered upon him so that his neuropathic condition is fixed or aggravated.

Liquor is like poison to shell-shock cases. One Scotchman told me mournfully that the war had wrecked his constitution and that now two drinks made him crazy, whereas he "used to stow away a bottle of whiskey and walk away with it." In another case a man had almost recovered after six months' good rest with light occupation. One evening some of his comrades took him along with them to a prize fight. He was given a small amount of liquor and this, together with the excitement, caused such a relapse that he had to be brought back to the home and put under the influence of opiates in order to control him. Then began another long period of convalescence. In order that such conditions could be more securely controlled and so that exactly the proper environment could be secured under trained specialists, it would seem to the writer that a special convalescent home for neurasthenics in the suburbs of a city would give speedier and greater returns.

The regular application of a program of vocational training is carried out with the shell-shock man as it is with the other patients of the convalescent homes. When a man who needs further treatment returns to Canada from England or France he is usually placed in an institution near his own home. If he is an orthopedic case, however, he goes to Toronto; if a severe mental case, as mentioned before, he enters a Provincial Hospital or the Central Hospital for Nervous Diseases in Cobourg, Ontario. He is given a short leave of a few days to spend with his family and friends, and then begins the program which aims at his mental, physical, and wage-earning restoration to civil life.

In Canada, in the early days of the war we thought, as perhaps you think now, that the men who return would be more or less seriously mutilated and crippled. At that time we thought that we should provide hospitals to care for very sick men. Wealthy people in the Dominion turned over magnificent residences where the men could loll in luxury and ease. Women with more zeal than judgment lionized the first detachments of returned heroes and vied with each other in the entertainment and attention to the first cripples. The soldiers who, themselves, thought they had done their simple duty were told so often that the government could never repay them for their services that they came to believe it. All these artificial conditions were ill adapted for the rehabilitation of nerve-racked men.

After some experience it was found that the men were deteriorating in morale and were getting less fitted to face the cold hard facts of ordinary life. They played cards, pool, billiards, and other enervating games; they read trashy magazines, or simply slept or sat away the time.

These men were not hopeless cripples. More of them had been rendered unfit for fighting by disease than by wounds. Out of the first 25,000 men who returned to Canada, only three per cent had suffered amputations of any kind. Fifteen hundred of them were tuberculous and the commonest disabilities otherwise were heart disease and rheumatism. In the army of 400,000 which Canada sent overseas, up to date, only thirty-four individuals have lost their sight. The man in the front line trenches has to be in the absolute pink of condition so that a comparatively slight disability throws him into the discard. Potentially these men were nearly as good as ever for industry and business. The government could not afford to leave anything undone that would restore them to perfect health so far as possible and fit them as nearly as possible into the position in which they could develop their highest productive power.

The institutions most necessary for treatment of these men were convalescent homes, not hospitals. The soldier would have to be treated in Europe so that he would recover sufficiently to withstand the hard ocean trip. The small convalescent homes which were first established were found to be ill adapted to their evident needs and too small to be administered economically. Then the Military Hospitals Commission began to plan and build new sanatoria and convalescent homes in large units exactly suited to the purposes for which they were to be used. The homes are usually situated near large cities so that expert medical services may be secured and each has a capacity of 300 to 1,000 patients.

In order to make proper use of the time of the soldier during the day, vocational training was introduced into every home and now the vocational building is an integral part of every new building plan. At first the classes were voluntary, but the revolutionary changes in discipline, morale, speed of recovery, etc., were soon so apparent that attendance in the vocational work was made compulsory for every man not excused by the medical officer as unfit.

Instruction is given in English, French, arithmetic, stenography, bookkeeping, typewriting, telegraphy, woodworking, shoe repairing, mechanical and architectural drawing, care and operation of automobiles, machine-tool operating, electrical wiring, gardening, poultry farming, etc. The daily program calls for an attendance of from four to four and one-half hours per day. The opportunities offered vary with the size and situation of the convalescent home.

Each man is interviewed soon after he enters the convalescent home and makes his choice of classes. If he has any good reason to change he is allowed to take up other work or to combine classes. Some of the ambitious men looked upon it as a chance of a lifetime and made astounding progress. Some patients learned enough so that when they were discharged from the army they took up new positions of advanced responsibility at greatly increased remuneration. A few were able to get instruction that they had always desired and started civilian life in an entirely new field. Most of the men accepted the vocational work as part of the régime and a few had to be driven. I could tell you some remarkable achievements of the men trained incidentally while they were getting well and some who got well mainly through the vocational training; but today we are chiefly concerned with the neurasthenics.

The nervous cases were treated individually by the Vocational Officer just as they were by the doctors. The persistent motive was to find some basis of interest in the man. The aim was to find something light and easy for him to do that would take his attention from himself. One class of work that seemed fairly attractive was making novelties and hand-wrought jewelry.

We secured some used cartridge cases from one of the battle fronts and used these for handles in making up such war souvenirs as envelope openers, paper cutters, shoe horns, nail files, bottle openers, bodkins, etc. Men made rings and brooches for themselves and their friends. The articles made could be kept by the patient if he paid for the raw materials or we sold them as war souvenirs to the public at reasonable prices, deducting the cost of materials and a percentage for disposing of them and keeping the balance as a nest egg for the man against the day when he should be discharged. The work was light and interesting; none of the things made required much physical effort or time; the man had an economic incentive in making a few extra dollars, and his strong instinct to create something was satisfied. Their heads stopped waggling; the bright strained look in their eyes disappeared; they ate well and slept well, and they got a grip on themselves.

Do not think, however, that there is any one class or group of classes that is a specific for nervous cases any more than that there is one medicine for all diseases. The main thing is to find some basis of interest in the person and there are almost as many different tastes as there are individuals. Very rarely the man would be interested in a class which required mental effort. I remember two cases where they started easily in mathematics and drafting and at the end of seven months had jumped from arithmetic to the end of trigonometry. One of these men became so proficient in machine drawing that he entered and satisfactorily filled a position as a mechanical draftsman at a salary exceeding greatly the one he had left to don the uniform. Most of the men like creative work with the hands. Light woodworking and machine-tool operation have been selected by a number of shell-shock cases. Most doctors would say offhand that a machine shop is too noisy a place for such patients. A good shop for instruction purposes is a quiet place and the men do excellent work in the main. I remember one outstanding case of bad nerves who threw a hammer at the head of the instructor one day during his first month when spoken to too quickly from behind. This man had been following an occupation before the war which is not listed among honest vocations. At the end of seven months he was a competent all-round machinist and said that he thanked God that he could go out and earn a good living at an honest trade. On Sundays or other days when he was not working in the shop he was nervous, irritable and excited during the first few months. Not always are we successful. One case of a docile man whose head waggled continuously, but not seriously, showed much enthusiasm for machine-tool work. He progressed satisfactorily under close direction for three or four months and then was taken away for a little more than a month for hospital treatment. When he returned to the convalescent home he immediately entered the class again, but had forgotten practically everything he had previously learned.

Another interesting case that is developing at the present time is that of a Boston boy. He came back from the front severely injured in the shoulder and with almost a total loss of memory. He was treated at Cobourg until his condition became stationary and was then sent to live with his sister. He was well nourished and comely, but completely apathetic and would not even wipe away a tear if it rolled down from his eye. He could not be trusted to go out alone even for one block because he could not find his way back, but would always wind up at a house where he used to live before the war. His sister used to bring him to the convalescent home every other day to have his arm massaged, but no interest could be aroused in him by offering him any of the instruction being carried out there. Finally after careful consultation, a woodworking bench with tools was set up in his own kitchen and an experienced teacher sent there every day. The attempt was made to get his memory to function again properly by having him learn and repeat the names of the tools and the woods that he was using. He appeared to be aroused from his sluggishness in a month, but then took a strong dislike to the teacher and balked. After another consultation it was decided to try instruction in telegraphy because he had once taken a partial course in this subject. Instruments were purchased, set up in his home, and a special teacher provided. This has been carried on for nearly four months and seems to have struck the right spot. He has learned the Morse alphabet again, knows how to spell a limited number of simple words and is capable of sending and receiving messages which do not run outside of his limited vocabulary. The hopeful fact is that he really exhibits some enthusiasm in the work. It may be necessary to switch to some other course later to rouse his consciousness fully and develop his power so that he can learn something by which he may earn a living. Perhaps we will fail, but a great deal of effort is justified in trying to save a boy of twenty-one for a life of usefulness instead of leaving him as an absolute dependent.

A number of doctors have prescribed farming and truly rural conditions for shell-shocked men, but I am sure that some of the soldiers who have been reared in the city (and one third to three fifths of them have been) would find the strange loneliness an aggravation rather than a balm. I know of one case especially where an intemperate man who had been a farmer appeared to be an arrested case in the convalescent home. It was arranged that he should be placed on a farm where he would not be exploited or pampered. Farm help is so scarce that the owner gave him thirty dollars a month in addition to his military pay. At the end of two and one-half months he returned to the home minus tremors and flushed face. He had gained considerably in weight and boasted of the fine time he had had.

I believe, however, that there is no single panacea in vocational training, or in any limited group of subjects, which will solve the problem of straightening up the shell-shock case. It is necessary to ascertain the thing in which the man is most interested and then to furnish work or instruction in that direction, no matter whether it is landscape painting or furrowing the landscape with a plough. With mild cases, the patient should be directed toward regular recognized wage-earning occupations. He should not be given special handicraft work in basketry, toymaking, etc., except in the early stages as a therapeutic measure. These are best adapted to seriously crippled men and will lead him to think he is not capable of holding down a real job.

The vocational training in the convalescent homes is only incidental and supplementary to the medical treatment. When a man becomes an arrested case he is discharged whether he has finished a course or not. If he is then unable to follow his old trade successfully he is a subject for vocational re-education. He is brought before a Disabled Soldiers Training Board, composed of a special medical officer, a vocational officer, and a layman who may be an employer, a labor organizer, a business man, a professional man, etc., representing the public. The man's desires and former occupation, together with his disability are carefully considered, and he is advised in regard to the vocations he may enter with probability of success. He, however, makes the choice himself so that he has the greatest stake in his future training. The effort is made to keep him as close as possible to his former work so that his industrial experience and skill may not be altogether scrapped. It is very evident that, if possible, he should be moved up to a position of greater skill and responsibility where he must use his intelligence more and his physical strength less.

This is often possible, but is not usually the case. The attempt is then made to place him in some occupation in the same industry, but parallel with his former work where his disability is not a serious handicap. If the central authorities at Ottawa concur in the recommendation of the Disabled Soldiers Training Board, the man passes out of the Army and becomes a civilian under the control of the Vocational Branch of the Military Hospitals Commission. He receives special pay and allowances running from a minimum of $46.00 a month, if he is a single man with no dependents, to a maximum of $93.00 a month in the case of a married man with five or more children under sixteen years of age. This allows him and his dependents to live respectably while he is getting his training. He may be sent to a technical school, a college of pharmacy, an agricultural college, a business college, a navigation school, or other special institution, or he may be regularly apprenticed in an industry. The courses usually last six to twelve months and are entirely free of cost to the man. He is given an extra month's pay at the end of his course, a position is found for him, and no deduction is made from his pension because of any proficiency or wage-earning power he has acquired at the expense of the government.

Thus Canada is trying to place the disabled men on their feet again in civilian life. The attempt is being made to eliminate the most pitiful by-product of war, the "old soldier." Having before her the experience of the United States after the Civil War, Canada is determined to have no crop of "carpet-baggers," pension mongers, and government alms takers with the consequent commonplace filching of national funds and degeneration of civic honesty. The gospel of the busy life for everybody is being preached and practiced among the returned invalid soldiers. Salvation through honest work applies to the hero home from France as much as to the mental defective or social delinquent. The satisfactory results already achieved in Canada stamp the vocational training and re-education as the most hopeful activities in rehabilitating the men who have placed their body and brains as a barrier against the horrible flood of German ideas that threatened to overflow the world, and who have given freely of themselves in this glorious service. The goal is to make the soldier's disability his opportunity and to prove that his sacrifice will furnish him a staff with which to support himself instead of a millstone to drag him down.

THE ECONOMIC LOSS TO THE STATE OF NEW YORK ON ACCOUNT OF SYPHILITIC MENTAL DISEASES DURING THE FISCAL YEAR ENDING JUNE 30, 1917

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TO check the spread of syphilis and to prevent syphilitics from becoming mentally diseased, it is proposed to establish an institution near New York City for the detention and treatment of syphilitics. It is believed that prompt treatment during the first stages of the disease would remove the danger of the involvement of the nervous system.

In this connection the question has arisen: Is the economic loss to the state on account of syphilitic mental diseases of sufficient magnitude to justify the establishment of such an institution? This study is an attempt to show the amount of such loss during the fiscal year ending June 30, 1917.

The economic loss to the state on account of any mental disease consists of two principal factors, viz.: The cost of the maintenance of the patients having such disease and the loss of earnings due to their incapacity. There are other minor factors involved, such as the expenses incurred by relatives of patients and the losses due to the sudden disruption of the patients' business relations. These items cannot be measured and no account is taken of them in this study.

COST OF THE MAINTENANCE OF PATIENTS WITH SYPHILITIC MENTAL DISEASES

Under the term "syphilitic mental diseases" we include general paralysis, psychoses with cerebral syphilis and psychoses with tabes dorsalis. The census of the patients in the civil state hospitals with reference to psychoses, taken on July 1, 1916, showed that there were 1,325 cases of general paralysis and 119 cases of cerebral syphilis resident in the hospitals. The cases of psychoses with tabes dorsalis were included in the general group of psychoses with other brain or nervous diseases, and were not separately enumerated. At the close of the fiscal year, June 30, 1917, there were 1,370 cases of general paralysis and 122 cases of cerebral syphilis under treatment in these institutions. No census of patients with reference to psychoses was taken in the hospitals for the criminal insane or in the private licensed institutions.

The syphilitic first admissions of the fiscal year to the several institutions were as follows:

	Total			General paralysis			With cerebral syphilis			With tabes dorsalis		
	M	F	T	M	F	T	M	F	T	M	F	T
Civil state hospitals.	719	197	916	681	185	866	31	12	43	7	..	7
Hospitals for criminal insane......	16	2	18	15	1	16	1	1	2	..	..	..
Private licensed institutions.......	24	7	31	23	7	30	1	..	1	..	..	..
	759	206	965	719	193	912	33	13	46	7	..	7

We roughly determine the average number of patients with general paralysis and cerebral syphilis under treatment in the civil hospitals by adding the number resident at the beginning of the year to the number resident at the end of the year, and dividing the result by 2. The average number thus found is 1.61 times the first admissions to the civil hospitals in these groups. Multiplying the total number of first admissions as shown in the above tabulation by this ratio, we find the total average patient population with syphilitic mental diseases under treatment in institutions in the state during the fiscal year to be 1,554.

The per capita cost of support of all patients under treatment in the civil state hospitals during the fiscal year, including hospital care, investment charges and cost of administration, amounted to $303.68. The per capita cost in the hospitals for the criminal insane and the private licensed institutions is not available, but it is probably not less than that of the civil state hospitals. Assuming, therefore, $303.68 as the uniform per capita cost in all institutions, the maintenance of the 1,554 patients with syphilitic insanity for a year would amount to $471,918.72.

LOSS OF EARNINGS DUE TO SYPHILITIC MENTAL DISEASE

Assuming that the onset of a syphilitic psychosis renders a person incapable thereafter of doing productive work, the loss at the time of onset would equal the present worth of the probable future earnings of the person during the balance of the productive period of life. We have, therefore, to determine the present value of the probable future earnings of all of the first admissions with syphilitic insanity to the several classes of institutions in the state.

The males and females are treated separately as the expectation of life and earnings of the two sexes differ materially.

The accompanying table No. 1, page 281, shows the number of syphilitic first admissions of each age, the average number of productive years lost by each individual at each age, the present value of an annuity of $1 for each period lost and the present value of the probable future earnings of the patients of each age. The mortality tables used in preparation of the table are the United States Life Tables of 1910, prepared under the supervision of Professor James W. Glover.

The valuation was made in the following way: For each present age, the expectation of life between that age and age 65 was found from the mortality tables. Then the value of an annuity certain for a term equal to such expectation was taken, at 4%.

It is recognized that this method does not produce exactly the same values as would result from the use of temporary annuity values, but these were not available for the tables used; in any event, the error involved is small when the arbitrary nature of the other assumptions is considered.

It is assumed that the period of productivity ends at the close of the 65th year, and that the average earnings are the same throughout the years of productivity. The average per capita yearly earnings of the males above the cost of maintenance are estimated at $500. This amount may be too high or too low, but all things considered, it seems a conservative estimate. The loss of earnings of the males thus determined amounts to $4,652,942.35.

Table No. 2, page 282, shows similar data relative to the females. It is assumed that the net earning capacity of the average female above cost of maintenance is $100 per year. On this basis the loss of earnings of the female patients is found to be $273,783.92.

SUMMARY

Combining the several amounts thus determined, we find the total economic loss on account of syphilitic mental diseases for the year to be:

Cost of maintenance of patients in institutions....	$471,918.72
Loss of earnings of males........................	4,652,942.35
Loss of earnings of females	273,783.92
Total loss..............................	$5,398,644.99

When it is remembered that patients with syphilitic mental diseases rarely, if ever, recover and that death occurs on the average within two years of the time of entrance in the hospitals, it would seem that humanitarian considerations alone would impel city and state authorities to do everything within their power to check the ravages of syphilis. Moreover, the enormous economic loss due to syphilitic mental diseases furnishes a financial argument that can not well be ignored.

Table No. 1

Loss of probable future earnings of male first admissions with syphilitic mental diseases in New York State, year ending June 30, 1917

Age at time of admission, years	Number of first admissions	Average number* of productive years lost by each individual at each age	Present value of annuity payable at end of year for term in preceding Column a_n	Present value of probable future earnings found by multiplying numbers in Column 2 by those in Column 4 and by $500
(1)	(2)	(3)	(4)	(5)
19	1	38	$19.3679	$9,683.95
22	1	36	18.9083	9,454.15
23	3	35	18.6646	27,996.90
24	3	34	18.4112	27,616.80
25	3	33	18.1476	27,221.40
26	3	33	18.1476	27,221.40
27	3	32	17.8736	26,810.40
28	16	31	17.5885	140,708.00
29	11	30	17.2920	95,106.00
30	12	29	16.9837	101,902.20
31	6	29	16.9837	50,951.10
32	21	28	16.6631	174,962.55
33	30	27	16.3296	244,944.00
34	24	26	15.9828	191,793.60
35	29	25	15.6224	226,524.80
36	25	24	15.2470	190,587.50
37	39	24	15.2470	297,316.50
38	38	23	14.8568	282,279.20
39	28	22	14.4511	202,315.40
40	35	21	14.0292	245,511.00
41	16	21	14.0292	112,233.60
42	40	20	13.5903	271,806.00
43	19	19	13.1339	124,772.05
44	23	18	12.6593	145,581.95
45	29	17	12.1657	176,402.65
46	28	17	12.1657	170,319.80
47	36	16	11.6523	209,741.40
48	17	15	11.1184	94,506.40
49	19	14	10.5631	100,349.45
50	32	13	9.9856	159,769.60
51	19	13	9.9856	94,863.20
52	14	12	9.3851	65,695.70
53	15	11	8.7605	65,703.75
54	13	10	8.1109	52,720.85
55	17	9	7.4353	63,200.05
56	12	9	7.4353	44,611.80
57	11	8	6.7327	37,029.85
58	15	7	6.0021	45,015.75
59	6	6	5.2421	15,726.30
60	12	5	4.4518	26,710.80
61	6	5	4.4518	13,355.40
62	8	4	3.6299	14,519.60
63	5	3	2.7751	6,937.75
64	5	2	1.8861	4,715.25
65	3	1	.9615	1,442.25
66	3	...	...	...
68	4	...	...	...
71	1	...	...	...
	759			$4,652,942.35

* Nearest whole number used.

Table No. 2

Loss of probable future earnings of female first admissions with syphilitic mental diseases in New York State, year ending June 30, 1917

Age at time of admission, years	Number of first admissions	Average number* of productive years lost by each individual at each age	Present value of annuity payable at end of year for term in preceding Column a_n	Present value of probable future earnings found by multiplying numbers in Column 2 by those in Column 4 and by $100
(1)	(2)	(3)	(4)	(5)
18	1	40	19.7928	$1,979.28
20	1	39	19.5845	1,958.45
21	2	38	19.3679	3,873.58
24	2	35	18.6646	3,732.92
25	1	34	18.4112	1,841.12
26	2	34	18.4112	3,682.24
27	1	33	18.1476	1,814.76
28	7	32	17.8736	12,511.52
29	3	31	17.5885	5,276.55
30	6	30	17.2920	10,375.20
31	3	30	17.2920	5,187.60
32	2	29	16.9837	3,396.74
33	8	28	16.6631	13,330.48
34	6	27	16.3296	9,797.76
35	9	26	15.9828	14,384.52
36	6	25	15.6224	9,373.44
37	5	25	15.6224	7,811.20
38	15	24	15.2470	22,870.50
39	11	23	14.8568	16,342.48
40	10	22	14.4511	14,451.10
41	5	21	14.0292	7,014.60
42	7	20	13.5903	9,513.21
43	5	20	13.5903	6,795.15
44	5	19	13.1339	6,566.95
45	8	18	12.6593	10,127.44
46	3	17	12.1657	3,649.71
47	6	16	11.6523	6,991.38
48	5	16	11.6523	5,826.15
49	12	15	11.1184	13,342.08
50	5	14	10.5631	5,281.55
51	4	13	9.9856	3,994.24
52	11	12	9.3851	10,323.61
53	7	11	8.7605	6,132.35
54	4	11	8.7605	3,504.20
55	5	10	8.1109	4,055.45
56	5	9	7.4353	3,717.65
58	1	7	6.0021	600.21
60	1	5	4.4518	445.18
61	1	5	4.4518	445.18
62	3	4	3.6299	1,088.97
64	2	2	1.8861	377.22
	206			$273,783.92

* Nearest whole number used.

PSYCHIATRIC SOCIAL WORK

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SOCIAL work has always been recognized as an important agent in the field of mental hygiene. When the Committee on Mental Hygiene of the New York State Charities Aid Association was formed, in 1910, one of its early steps was to engage a social worker for the after-care of patients discharged from the state hospitals for the insane; and it has been advocating ever since state-wide social service for these hospitals. The earliest publications of The National Committee for Mental Hygiene recognize the social character of the problems created by nervous and mental disease and lay stress on the fact that an important part in the movement must be taken by the social worker. Though this belief has been firmly held by those most closely connected with the mental hygiene program, it has not been put into general practice as rapidly as might have been expected. This slow rate of development is no doubt due in large part to the almost total lack of persons properly prepared for psychiatric social work, and to the lack of definite knowledge among physicians and the public of the character and significance of social work in this connection. Entire ignorance or curious misconceptions of the nature of social work are the rule, not only among the public at large, but among professional people. The term social work has not even found its way into our encyclopedias. The many and varied activities known by that name are united as yet only by a slender thread of common purpose, and have not evolved principles or formulated methods that give them a unified character, which may be recognized as professional. Social work can only be regarded as a profession in the making. Meanwhile there are indications that a rapid increase of social work in the field of mental hygiene is about to take place. Since its effectiveness as an aid in the care of patients has been demonstrated in a number of hospitals for mental disease in the country, it is to be hoped that our government will in some way employ this agency in the recovery of soldiers with nervous and mental disorders.

A new division of social work which may conveniently be known as psychiatric social work is coming to be recognized as a definite field requiring special preparation. It is important to reach a clear understanding of this type of work, first, for the sake of the practical benefits to patients to be obtained through the increase of social service that is bound to come with better understanding, and, second, for the purpose of presenting to young men and women about to choose a profession the interests and opportunities to be found here. There are many able persons who might turn to social work, who are still under the impression that it is an easy and accessible home outlet for the missionary spirit, or a convenient way for persons of kind hearts and common sense, without education or training, to put their abilities to good use; while college graduates of today demand a vocation that calls for brain power and offers a field for progress and development and at the same time affords an opportunity for service. The impulse that actuates them is the scientific spirit; therefore, social work must answer for them the question, "Is there a future of scientific work for the social worker"? There is no ready answer to this question; nor can it be answered satisfactorily until the fundamental concepts of social work have been clearly defined and its practical relations to adjacent fields of activity carefully considered. This paper does not presume to be an attempt to dispose of the question, but merely to indicate the outlines of some of the concepts and relations of social work in the field of mental hygiene. It would not seem to be possible to forecast in any way exactly the course of those forms of activity that are now known as social work. The most that we can do is to take notice of the indications of development that are to be observed at present—to watch the straws that show the way the wind is blowing. Direction, extent, and rapidity of growth will depend largely upon the quality of persons who in the future follow the calling of social work. The expectation of largest and surest results depends upon the extent to which social work shall appear to able persons as a pursuit containing possibilities of satisfaction to a trained mind and an active personality.

The term social work has been loosely used to include many forms of activity by many types of persons with various kinds of training and experience; consequently it signifies different things to different persons. Our patients are sometimes led to think that they may secure positions in social work; and a medical student suggested that the difficulties of a psychopathic delinquent patient might be solved by making her into a social worker. In a recent article in MENTAL HYGIENE, a physician refers to the social worker as a nurse. Mental testing and social work are very often thought to be identical by applicants for training at the Boston Psychopathic Hospital. The name social work is still vague enough to cover almost any form of work for human welfare that chooses to seek its shelter. But in the obscurity the outlines of four well-marked departments stand out:—first, educational and legislative work; second, community work; third, research; fourth, individual work—social care of the individual—commonly known as social case-work. Any particular social agency probably exists primarily for one of these four purposes; but at the same time it contributes to one or more of the other groups. It is with individual work and research that the psychiatric social worker is chiefly concerned.

In this work for individuals, the social worker carries vital responsibilities. Any one in any profession who undertakes to advise another person in a crisis, in the midst of some deep and tragic experience, or under the influence of some complicated and profound conflict in life, finds that all the resources of his mind are drawn upon, to see the facts, to understand their relation to the persons involved, and to form a judgment of the action to be taken. To go further and assist in carrying out the advice given makes additional demands on his powers of mind and personality. Because he deals with vital matters, the social worker enjoys a specious prestige. He must be rated on the strength of the importance of the responsibilities that he carries and the value of the materials with which he works, rather than according to his relative knowledge and achievements. This is a pragmatic necessity; for men associate in their activities on the ground of significance of function and not of academic prowess. The social worker has been inclined in the first burst of enjoyment of his easily won prestige to overlook this distinction, and to occupy somewhat ingenuously his seat among the "experts," overlooking the fact that his "expertness" is in quality something different from that of the physician, lawyer, or engineer, who have assimilated the funded knowledge tested and retested by generations of students, and again retested by their own experiences; while the social worker has for his guidance little more than his accumulation of experience, a collection of unorganized observations, methods acquired by rule of thumb, convictions of general principles hastily drawn from scanty data—in short, a kind of well-developed common sense. In a given instance, such expertness may be of higher practical value in a certain situation than the skill of an expert of any of the older professions in a situation of equal importance in his field; and it is not to be discredited or undervalued; for in any circumstances it has a high practical value. At the present time in the field of social work it is of the first importance since it is all that there is. The consideration that makes the discussion worth while is that full recognition of the fact, that the social worker only by courtesy professionally ranks equally with members of older professions, will tend to hasten the day of sound education in preparation, and of devotion to scientific methods of development in social work. True insight into his status also enables the social worker to associate more comfortably with his fellow workers in other fields. Some of the friction commonly known to occur between physicians and social workers is undoubtedly due to an assumption of expert authority by the social worker, which the physician of course knows to be unwarranted. Among the great personalities distinctions of acquired power are apt to disappear. When the rank and file meet the great men in close association, they are not reminded of their inferiority; for the great man is conscious of the small part of the universe that he himself has mastered and is not particularly aware of the difference between the heights of his thought and the lowland of his associates, since his concern is with their common distance from perfection. It is within the rank and file that the difference between native capacity and expert skill is significant. The average for native ability among social workers is probably high; but in professional education and in trained intellectual ability, social work is obviously deficient to a large degree.

The average social worker engaged in case work has not the concepts or habits of thought to fit him to develop his work along scientific lines, to promote, that is, a science of social case-work. The ablest persons from the ranks are continually being claimed by executive positions; and case-work from the point of view of scientific interest is neglected. This situation will continue until education for social work approaches more nearly the character of medical or legal training, so that a larger number of able and well prepared persons may be found for all positions. Meanwhile the foundations of scientific work may be laid by drawing on the material of established sciences. The social worker guided by the sociologist, the psychiatrist, and the psychologist, especially, may perhaps enter forthwith upon the borderland of knowledge that lies between the intuitive and the scientific, and with the addition of his acquired practical skill and practised observation in his own field, begin the formulation of principles, which may eventually constitute the applied branch of sociology.

For practical reasons it is desirable that social workers should be accorded a rank unmerited by professional training; for good social work demands the calibre of person who goes into medicine, law, or education. Such persons would rarely be attracted to social work if the status accorded them were not based upon the responsibility of their functions rather than upon their lack of scientific preparation. In departments where this fact is not recognized, the official discomfort of inferior status, (which should be distinguished from personal social relations with associates, as it is quite a different matter), is bound to act as a deterrent to the entrance into the work of persons of high grade. Furthermore, the official status of the worker is important because it affects the quality of his work through stimulating or repressing initiative, industry and interest. For example, a psychiatric social worker in a hospital for mental diseases ought to have special knowledge of social matters, capacity for independent judgment, analytical ability, personal power. This is the type of woman who under other circumstances might have studied medicine. In social work, her academic education does not ordinarily go beyond that of the degree of A. B., and her special training has probably been not more than a year's work. Her acquirements compare unfavorably with those of the trained physician. However, it would seem best that the official status of the social worker, even now, should be that which it must be if she had received full professional training; for by this means the interests of immediate work and future growth of the field will be best served. At the same time the social worker should not lose sight of the discrepancy between her acquirements and those of the physician; for therein also lies a serious obstacle to progress.

So far social case-work has dealt mainly with the elementary facts of social adjustment, income, employment, housing, housekeeping; and with the primary social problems, how to find a job, to bring a deserting husband from another state, to get milk for the baby, convalescent care for the sick, to move a family to a better house. Since the elements of a subject must be mastered before its more complicated facts can be approached intelligently, these elementary processes are not to be slighted nor thought of lightly. Besides, they are not necessarily easy to accomplish, and although relatively simple to comprehend, they may be both complicated and difficult from the point of view of performance. Considerable progress, too, has been made in the ease and precision with which facts of this sort are handled in individual cases. Without doubt data could be obtained to show a marked improvement in case-work in speed and effectiveness; that is, it would probably be possible to measure our advance by showing a larger percentage of successful results achieved in a shorter period, and thus to make apparent a quantitative difference between the accomplishment of the untrained worker of the past and the social worker who has received such systematic preparation as the present day affords. In both types, however, you find economic interests, and preoccupation with the elementary social facts; the difference between trained and untrained being a matter of degree, which, it need not be said, is a difference of great practical value. But a qualitative difference is beginning to appear. We see case-work about to pass into a psychological phase. Many influences have been bearing upon this change, some of them going back ten years or more. No vital change occurs in a year or a decade; slight signs appear, increase in numbers and significance, gradually and imperceptibly changing the emphasis until finally the subject appears to the majority from a new point of view. No one will be able to say when or where factors of personality rather than factors of environment began to be the dominant influence in social case-work. It is clear that environment prevails at present. It is becoming evident that personality will become the leading interest in the future. A distinct impetus along this line of development comes from the association of social work with psychiatry in the care and study of psychopathic persons. As in other fields, knowledge of the normal has been drawn from study of the abnormal, so from social psychiatry we shall gain understanding of normal human associations.

If social case-work is understood to mean the effort to organize all elements within the individual and his environment, so that he shall be adapted to social life as successfully as possible, it is clear that it should always be in some degree psychiatric. In the same way, all social case-work may be regarded as medical social work, in so far as the bodily health of the individual is of primary concern in every case. In short, all matters of individual human life are in some degree the common factors of case-work, whether the work is being done for dependent families, neglected children, homeless men, unmarried mothers, delinquents, or sick persons. The distinguishing feature of any specialization is the emphasis of a point of view, which leads to growth of knowledge along the line of special interest and to particular skill in dealing with cases of a certain type. The characteristic then of psychiatric social work is that it approaches social case-work or social research from the standpoint of psychiatric and psychological analysis of personality, and for the purpose of adding to psychiatric knowledge. It may be carried on in hospital, court, factory, or social agency. It requires workers with a training that will fit them to collect social data necessary to psychiatric diagnosis, to understand the significance of the physician's diagnosis, and to afford social care that will contribute to medical treatment. It presupposes training in the general principles and methods of social case-work, which however may be acquired through clinical work with psychiatric cases, as well as with any other group of cases, since the fundamental factors are common to all types of cases, and since also in the families of psychopathic patients all other types are sure to appear. Adequate equipment, which is not yet provided by any university or school, calls for at least two years' graduate work with advanced courses in psychology and sociology, some elementary knowledge of medical sciences and psychiatry, and at least a year of experience in case-work.

Stimulus to undertake preparation lasting two or more years should be found in the fact that the development of psychiatry, considered both as a science and an art, is dependent to a large extent upon social data and social experiment. Studies of heredity, of the incidence and progress of certain diseases, of the etiology of others, call for social investigation. Satisfactory conclusions on methods of treatment of mental disorder in the community cannot be reached without the co-operation of social work. Finally, if the study of human behavior is to be carried on into a science of character, there will clearly be need of the specially trained psychiatric social worker for purposes of observation and experiment in the field of social data.

To sum up, although social work has always been recognized as part of the mental hygiene program, its activities have been slow to spread. The reason, at least in part, may be found in lack of social workers with suitable preparation and in general ignorance of the nature of the work. Since there are indications of an increase in psychiatric social work in hospitals for mental disease and probably in war work, clearer understanding is important to mental hygiene, especially for the purpose of enlisting able persons for training. There are many popular misunderstandings of social work, which identify it with nursing, with mental testing, with occupational therapy, with neighborliness. The term social work embraces a varied group of activities, which from the point of view of function include three departments, first, work for individuals or case-work; second, educational work; third, community work; fourth, research.

By reason of the vital character of the responsibilities that the social worker carries, he holds a position in relation to the professions that cannot be justified on the ground of professional fitness. It is perhaps necessary that the social worker should for the time being occupy this unmerited high rank; since the future development of social work demands persons of professional calibre, and since such persons would rarely be attracted to social work, if the status accorded them were not based upon responsibility of function rather than upon scientific ability. On the other hand, the social worker must avoid the danger of resting satisfied with this easily won prestige, so that he neglects to apply himself to the scientific development of his subject and to the advancement of social education. At the present time, social work is obliged to look to other professions for scientific leadership. Especially through psychiatry, psychology, and sociology an influence may be expected that shall lead eventually to the establishment of social work as the applied branch of sociology.

In the past, the economic interest has been paramount in social case-work, and is still dominant; but there are indications that the dominant interest is becoming psychological. This trend receives a strong impetus from social psychiatry, which through the study of the abnormal seeks knowledge of normal character.

Social case-work, the effort to adapt an individual successfully to social life, must always be in some degree both psychiatric and medical. All forms of social case-work have common factors, and the special branches are characterized by the interest upon which they focus. The main interest of psychiatric social work is personality, and its ultimate object is to contribute to knowledge of social psychiatry, which in turn has for its goal the advancement of mental hygiene. Adequate preparation would require at least two years' graduate work including a year of social case-work. The social worker thus trained should find large scientific opportunities in the field of social psychiatry.

ABSTRACTS

THE IMMORAL WOMAN AS SEEN IN COURT: A PRELIMINARY REPORT. By V. V. ANDERSON, M. D. *Boston Medical and Surgical Journal,* 177: 899–903, December 27, 1917.

This report aims to throw some light upon the woman offender, her needs, her physical and mental condition, and the main lines of treatment indicated. A group of 100 women who appeared in the Municipal Court, Boston, was selected, each of whom had been arrested for an offense against chastity, and it is likely that the group is representative. Of these 100 immoral women, 56 were first offenders, 25 were second offenders and 19 were recidivists. The majority were young, though none were under seventeen, these being tried before the Juvenile Court. The oldest was 54 and the average age was 26 years. Seventy-four were under thirty years of age. Thirty-four were in the habit of using alcohol and twelve were addicted to the use of drugs, while 54 showed no evidence of either.

Of these, 49 had a mental level below twelve years, 26 from twelve to sixteen years, and 25 of sixteen years or over.

The following table shows the mental diagnosis of these women:

Normal	20
Dull normal	32
Feebleminded	30
Epileptic	6
Alcoholic deterioration	2
Drug deterioration	2
Psychopath	7
Psychosis	1
	100

Fourteen were in good physical condition, 42 in fair physical condition, 36 in poor physical condition and eight in bad physical condition.

The relationship between their physical condition and industrial efficiency is shown by the following table:

Employment	*Good physical condition*	*Fair physical condition*	*Poor physical condition*	*Bad physical condition*	*Totals*
Regularly employed	1	12	3	1	17
Irregularly employed	5	14	12	2	33
Odd jobs	0	0	1	1	2
At home	4	5	8	0	17
Do not work	4	11	12	4	31
Totals	14	42	36	8	100

Venereal diseases were not included in classifying the physical conditions as it seemed best to consider them separately. Among these 100 women, 39 had syphilis and 32 gonorrhea and in ten cases the condition was combined. In all, 61 individuals were suffering from venereal diseases. This is a conservative figure as only positive blood tests and smears were counted.

The following table shows the high correlation between the frequency of offense and the mental condition of these individuals.

Mental Condition	*First Offenders*	*Second Offenders*	*Recidivists*	*Totals*
Normal	16	3	1	20
Dull normal	19	11	2	32
Feebleminded	11	8	11	30
Psychopath	4	0	3	7
Epilepsy	3	2	1	6
Alcoholic deterioration	1	0	1	2
Drug deterioration	1	1	0	2
Psychosis	1	0	0	1
Totals	56	25	19	100

Of these 100 women, 27 possessed good or fair mentality and were in good or fair physical condition; 25 possessed good or fair mentality and were in poor or bad physical condition; 29 were in poor or bad mental condition and in good or fair physical condition; and 19 were in poor or bad mental condition and in poor or bad physical condition.

THE NEED OF CLOSER RELATIONSHIP BETWEEN PSYCHIATRY AND THE MEDICAL SCHOOLS. By MAJOR ARTHUR H. RUGGLES, M. O. R. C., *American Journal of Insanity,* 74: 149–155, October, 1917.

The author states that psychiatry needs a greater number of men in its ranks and that these men should have the best possible training for their chosen work. Emphasis is placed upon the need of a higher and more uniform standard of psychiatric teaching in medical schools. Few of these schools at present provide courses in which the student must himself examine patients, and very few make these practical courses compulsory. This should be a requirement in a medical school of class A.

Better teaching in normal and abnormal psychology is also urged. Several of our schools give courses in "Psychology as Related to Psychiatry," and this should be followed by all. Nearly all schools now give courses in neuropathology, but many fail to require of the students the study of lesions under the microscope which is essential to a thorough knowledge of clinical psychiatry.

The general medical practitioner should be trained to recognize early symptoms of mental disorders. Teachers of psychiatry should have a wealth of psychiatric material at their immediate command, and for this they should be closely connected with a modern psychopathic hospital.

For the men wishing to enter the field of mental medicine, a course in mental hygiene, dealing with the causative factors of mental disorder, their prevention and the treatment of pre-psychotic symptoms, should be available. This course should include practical instruction in testing the degree of mental development and in ways of training the mental defective.

The author next urges that questions concerning mental disease should be included in state board examinations.

Dissemination of knowledge of psychiatric opportunities to men in medical schools is suggested. An outline of the purpose of the courses in psychiatry, followed by talks by members of the department showing the opportunities open for a man specializing along this line, should be presented to the first-year medical student. In the second or third year of his course the opportunity for research in this branch should be explained. After a student has spent two or three years in the medical school, institutions should receive him for work in the summer months as a laboratory assistant or a clinical clerk, allowing him some financial return.

Every medical school should offer organized post-graduate work in neurology and psychiatry for physicians who may wish to specialize in mental medicine after they have been engaged in general practice. Such course should provide definite work in the laboratory, wards and out-patient departments, and be made as intensive as possible, but a post-graduate student should be freed as much as possible from routine work involved in administrative problems.

The author advocates case-teaching by some psychiatric center's sending case records to subscribers, giving abstracts of cases presented at staff conferences, and points out the benefits from this procedure to the instructor, members of hospital staffs as well as to the private practitioner. The hospital conducting this course might receive reports of cases from other institutions and select the ones of greatest value illustrating points of interest in differential diagnosis, new methods of examination or treatment, or mistakes in diagnosis as revealed by autopsy or by the unexpected recovery.

OUGHT LIMITED RESPONSIBILITY TO BE RECOGNIZED BY THE COURTS? By Charles P. Bancroft, M.D. *American Journal of Insanity,* 74: 139–48, October, 1917.

Two opinions have prevailed as to the problem of criminal responsibility; one, that the fixing of responsibility is outside the physician's province; the other, that the problem is distinctly medical. The opinion expressed by Ballet and others at a congress of alienists and neurologists held at Geneva and Lausanne about ten years ago is cited, that "since questions of responsibility are of a metaphysical and juridical order and outside the physician's competence, a judge is not entitled to demand the physician's opinion concerning them;" also the view of Toulouse and Crinon, expressed by them in an article published in the *Psychiatric Review* in 1906. These medical men believed the problem of penal responsibility to be a psychological one and that only the physician. trained in modern psychological methods would be qualified to render the advice needed in determining responsibility through a careful examination of the criminal's mental state. Ballet insisted that the question of responsibility is a metaphysical one and should be determined ultimately by the court. According to this view, the alienist's obligation would cease after he had pronounced the individual as sane or insane, and the placing of responsibility would then rest with the court. The medical profession and a large portion of the legal will not assent readily to this conclusion. The jurist must be guided by the experience of the physician. The problem must be ultimately determined by the alienist.

However, the legal profession errs in expecting the physician to draw an exact line between absolute responsibility and complete irresponsibility. Well-defined lines of demarcation between full responsibility and total irresponsibility cannot always be drawn, since imperceptible gradations mark a transition between different mental mechanisms and their expression in conduct. The psychiatrist can generally with fair accuracy diagnose total irresponsibility, total responsibility and modified responsibility.

The author cites the view held by Grasset in his book, *The Semi-Insane and the Semi-Responsible*, in which "attenuated responsibility" is elaborated. Grasset believes that the question of responsibility is psychological and consequently medical, and by no means metaphysical. He says, "When a semi-insane individual has committed a misdemeanor or crime, he should be both punished and treated at the same time."*

A committee for determining the relation of insanity to criminal responsibility, with Edwin R. Keedy as chairman, presented to the Institute of Criminal Law and Criminology a Criminal Responsibility Bill—which was criticized by the editor of the *Harvard Law Review* in that it would introduce the doctrine of partial responsibility—the holding of lunatics for part of their crimes. Professor Keeley replied to this criticism contending that partial responsibility in no way involved partial insanity. It was also stated that the adoption of the doctrine of partial responsibility would lead to compromise verdicts. In reply to this Keedy states that "this result is not nearly so likely to happen as is the acquittal, under the present rules, of a defendant who is known to have lacked some of the mental element necessary for the full crime charged."†

Responsibility and punishment for guilt must be entirely dissociated in our minds while attempting to solve the question of personal responsibility. Centuries ago, society devised a system of punishment for wrong-doers. In early days cruel punishments were exacted. Punishment was at first retaliatory; later, its purpose was mainly deterrent; now, the aim is the reformation of the criminal with a view to his return to a normal and useful life if possible. Punishment should be made to fit the individual rather than thè crime. Since it exercises a salutory influence upon the semi-responsible mind and supplies an incentive toward right conduct, a reformatory sentence may prove to be a wiser procedure for a semi-responsible offender than confinement in an institution for the insane.

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* The Semi-Insane and the Semi-Responsible. By Joseph Grasset, tr. by S. E. Jelliffe. New York: Funk and Wagnalls, 1907. p. 397.

† Harvard Law Review, April, 1917, p. 554.

"Responsibility is practically liability for wrong doing. What is the state of mind that makes a person liable for his misdeeds? To be liable for wrong doing a person must be able to reflect upon the nature and consequences of his act, to consider and weigh the various motives leading to its performance, to consider whether the act is merely selfish and thereby harmful to others, whether in fact the act is wrong in the light of the moral, the common or the statutory law, and finally he must possess the power to make a decision in his own mind whether to do or not to do the act. Liability presupposes the ability to exercise reason, apply corrective judgment, and the power to choose between different courses of action. Motiveless acts are evidence of insanity and irresponsibility. (Mercier, Criminal Responsibility, p. 156.) The insane person justifies his action. He cannot think his conduct is wrong, because from all the reasoning at his command he believes that he is right, and what he does must be justifiable. To his impaired corrective judgment the established laws of society make no appeal, nor do they exercise upon his distorted mental perspective any restraining influence.

"Responsibility or liability must be measured by the degree of judgment and will power of the individual. These mental states vary in the normal person. Temperament exerts a profound influence upon conduct in the perfectly sane and responsible person. A man with what we say is a normal mental equipment, under the stress of strong passion, may be so upset by storms of feeling as to become the victim of his own impulsivity, still we say he is responsible because he could and should have weighed the consequences, and should have exercised his will power to control his conduct. Another man with bad hereditary antecedents, brought up in wretched environment, with limited education, absolutely no moral instruction, depraved tastes and associates, and a meager mental equipment cannot be held to the same standard of liability as the former more favored and better endowed individual. In other words, identical standards of responsibility do not apply alike to all individuals. Liability varies with the person. The moron, or high-grade imbecile, ought not to be measured by the same standard of responsibility as the normal person, or the low-grade imbecile, or the idiot."

Underlying motives must be analyzed. Too great emphasis is often placed upon inherited evil tendencies. In the borderline case, the psychopath, the constitutionally inferior, the sexual pervert, commitment for observation to an institution is the desired procedure, in order that an intensive study may be made to detect defects in judgment, reasoning capacity and will power of the individual.

"When modified responsibility is recognized by the courts as a logical conclusion founded on a scientific psycho-pathology, then the psychiatrist can make to the court a report that is entirely consistent with our present knowledge of normal and abnormal mental processes. He will feel that he is not playing into the hands of the partisan lawyer, but is expressing an opinion founded on sound data. Such conclusion and final report to the court are in harmony with our knowledge of mental mechanisms and their conduct reactions. The alienist, in recognizing modified responsibility and its important relation to conduct, does not stultify himself by expressing opinions which he really knows are inconsistent with sound pathology."

In states still retaining capital punishment the doctrine of modified responsibility is especially helpful in case a homicide has been committed by a person whose mentality does not measure up to normal and who, nevertheless, may pass the superficial tests of responsibility.

"Recognizing the rational basis of the doctrine of limited responsibility, the following conclusions appear to the writer psychologically consistent, presenting a course—a *modus vivendi* that ought to be mutually acceptable to the court, the jury, and the expert:

"I. The physician's competence does extend to the determining of responsibility.

"II. Every case is potentially different from every other case, and therefore calls for special individual study.

"III. No general inclusive juridical rule can be devised that will fit alike all cases in which the question of responsibility is raised.

"IV. The finding of a mental status involving responsibility, irresponsibility, and limited responsibility is based on rational psychology and ought to be logically satisfactory to both the medical and legal professions."

COMMITMENT TO PSYCHOPATHIC HOSPITAL AS RELATED TO QUESTION OF PERSONAL LIBERTY. By Richard Dewey, M.D. *The Journal of the American Medical Association*, 70: 292–93, February 2, 1918.

"Mental competence is abolished in insanity, and also in patients not strictly insane, as hysterical subjects, and victims of drink or drugs, of toxic delirium, and of cerebral hemorrhage, tumor or trauma. Patients in each of these conditions are unable to act responsibly and, if placed under treatment or control, must be made the subject of a judicial record of insanity; otherwise admission to institutions is forbidden.

"Patients and their friends in great numbers constantly refuse thus to fix what they call the 'stigma' of insanity on the patient. They will submit to untold distress before placing a 'ban,' as they think, on a loved one or on a family, by a public hearing or a court inquest followed by a public record of insanity. Proper care and treatment are thus denied or delayed for weeks, months and years, and incalculable harm results. In the populous communities in every state of the Union, each year, scores, even hundreds, of those suffering from mental disorders reach the incurable stage before treatment is secured. The reports of institutions, which generally show a duration of insanity of a year or more in a majority of all admitted, clearly prove that these cases are often chronic and practically incurable before these patients reach the insane hospital; and it is often too late to hope for recovery when the legal steps are finally taken. In any event, the suffering and injury entailed on all concerned further intensify this evil, which all our communities endure without seeming to be conscious of its extent. Of course, certain cases are incurable at the start; but these may be regarded as a minority. Naturally, the main reason of all this difficulty and misfortune is the proper jealousy of the law regarding personal liberty; and my object in presenting this matter is to inquire whether any method can be adopted whereby personal liberty can be equally well conserved and a source of injustice to the unfortunate at the same time removed.

"It is certain that no stigma ought to attach to mental illness any more than to physical illness; yet this is one of the numerous things that *is* although it ought not to be. Probably only advancing education and enlightenment will remove the idea of a supposed stigma attaching to mental disease. I may here mention some of the facts that conspire to produce this unfortunate result.

"To the eye of the law, so far as legal proceedings are concerned, insanity and criminality seem to look much alike. In both cases, the individual is under arrest or detention; is in the attitude of an accused person, and in one case is found guilty, and in the other, pronounced *non compos mentis*. Then sentence is passed by judge or jury, and the person held in custody is sent 'over the road' to an institution of the state—the asylum or the prison, as the case may be. Each of these two roads, to the undiscriminating public eye, seems to lead to an equally undesirable destination. Another situation exists tending to perplexity on the part of the uninformed. Crime is at times a result of insanity; insanity is also used as a plea in extenuation of crime, and cause and effect are thus confused in the minds of the masses. Finally, the old but still surviving superstition that regards insanity as a 'demoniacal possession' adds in some instances to the sense of shame. There is no more reason to associate disgrace with insanity than with rheumatism or Bright's disease. Indeed, when it comes to a question of blame or discredit, the latter are in reality just as often the sequel of evil habits or immoral conduct as is insanity.

"In some of our more progressive states, it has been sought to meet the difficulties here described by 'voluntary' and 'temporary' commitment laws or 'emergency' commitments. These have undoubtedly been of great benefit. Their benefit, however, is exceptional and partial. Only in a few instances have these measures been adopted, while the ancient and outgrown methods still generally prevail. It would be well if the patient could go to the psychopathic hospital precisely as to any other; but the possibility of wrongful detention in such hospital, and the necessity of safeguarding personal liberty, have resulted in these legal restrictions which deny admission to all, even though needing such benefit, except on condition of a public declaration or verdict of insanity. The same condition also applies to all who enter the state hospitals for the insane.

"The law at present accompanies the patient to the door of the hospital and leaves him there subject to all subsequent chances. I believe that a majority of the patients do not need attention from the law before commitment, while there are numerous cases that the law should follow and be cognizant of after as well as before admission to the institution. . . .

"It is now universally recognized that every city of any considerable size requires an institution for the care and detention of the large number of persons temporarily or permanently incapacitated from a mental standpoint—in other words, the psychopathic hospital is more and more seen as a necessity. Such hospitals are already in beneficial operation, but their usefulness could be largely increased by making them more free of access. Patients should be admitted in the same manner as those admitted to other hospitals and freely discharged as well, except in the case of patients who are in a condition making it unsafe or injurious to themselves or others to be at large. . . .

"In this connection, it is pertinent to speak of the meaning of the word 'insanity.' This word has never been defined satisfactorily from either the legal or the medical standpoint. It is as indefinite when applied to the mind as is the word 'sick' when applied to the body. Just as there are all possible degrees of sickness, so there are infinite gradations of so-called insanity. Some bodily sickness is so severe that it confines a patient to bed; in other cases, the patient is up and about; patients may be seriously and incurably sick and yet walk the streets and transact business. In the same way the term 'insanity' is applied to innumerable conditions. In some cases, it means total loss of mind. In others, a great degree of mental clearness remains. Some patients need close confinement; others can have entire freedom; still others, though decidedly insane, are bright and capable in certain directions; some patients are only temporarily or periodically affected. Insanity is a word without any uniform significance. It would be well if it could be omitted from scientific writings. The term 'psychosis' is applicable to all forms of mental disorder or derangement, and carries with it no offense."

FORTIFYING THE CHILD AGAINST MENTAL DISORDERS. By Everett S. Elwood. Proceedings of the Tenth Congress of the American School Hygiene Association, 1917. P. 269–76.

The author states that much time and energy is being expended in promoting the bodily hygiene of the school child, whereas his mental hygiene has not received the attention that it deserves. This is probably due to the superstition which has clung to mental disease for centuries and to the widespread conviction that insanity is so obscure and indefinite that nothing much can be done toward its prevention.

Dr. Stewart Paton's definition of health is quoted as "a state of mind and body in which the adjustments of the individual to his environment are relatively good, while in disease, of which insanity or mental disorder is a special form, they are insufficient or imperfect." There is no sharp line of distinction between sanity and insanity, the difference between mental health and mental disease being one of degree, rather than of kind.

The author then goes on to state that the causes of mental maladjustment may be divided into two classes: first, those of a material nature which enter from without, as various forces introduced into or developed within the system and carried through the blood stream to the brain; and second, those of a functional nature developing within the brain itself, which might be described as bad mental habits.

One of the principal poisons entering the mental mechanism from without is alcohol. Several forms of insanity are caused almost entirely by its excessive use. Alcohol was the causative factor in 10.3 per cent of the first admissions to the New York State Hospitals for a period of nine months, ending June 30, 1916. The fortification of the child against the types of insanity caused by alcohol can best be brought about by giving him a thorough knowledge of its effect and developing his resistance to temptation.

The second principal external cause of nervous mental disorder is syphilis. This is the essential cause of general paralysis which claims about 14.5 per cent of all first admissions, and is responsible for nearly one fifth of the male admissions to the New York State Hospitals. The prevention of general paralysis depends entirely upon the prevention of syphilis. The author states his firm belief that the youth of today should have a clear knowledge of the ravages of diseases associated with immoral living, and that the school should supply training which a large number of homes do not provide.

Of the causes of mental disorder seeming to arise within the mind itself, one of the most common is excessive worry. Many of us carry about continually a large bundle of worries; many of us spend much time reviewing the past and wishing things had been different. Severe mental distress may result from brooding over that which cannot be changed. The child's attention should be directed to the present and the future, and he should remember the past only for the lessons that it has taught.

Excessive introspection often accompanied by a feeling of oversensitiveness and inferiority is another evidence of lack of good adjustment. Protection should be given the delicate child against such mental habits during the age of puberty.

A description is given of a case of dementia praecox reported by Dr. August Hoch. This form of mental disease constitutes 18 per cent of all admissions to the New York State Hospitals for the insane, and Doctor Campbell of Johns Hopkins believes that 39 per cent of this form of insanity is preventable.

Danger signals should be recognized early. Excessive introspection, brooding over the impossible, oversensitiveness, together with a feeling of inferiority and worry over trifles should serve as a warning to the teacher. She should bring the child to the attention of a physician skilled in mental diseases who will be able to prevent many serious disorders and keep a large number from leading lives of failure and discouragement through mental inefficiency. "A child can be taught to look his worries straight in the face. He can be helped to analyze his fears by carefully examining the causes of his anxiety, and in so doing he will unconsciously minimize much of the emotional element which is disturbing to mental health. The wise and progressive teacher will occasionally comfort the child by assuring him that all make mistakes sometimes. She will teach him without his knowing that he is being taught, that one's anxieties and worries and discontent depend more upon the state of mind than upon the environment. A normal state of mind is undoubtedly one that finds a certain amount of satisfaction in daily life. No individual can hope to find a sufficient amount of happiness outside of his daily work to keep him in the best of mental health, if his daily work is the source of constant distress and displeasure. If he is unable to change the nature of his occupation he should do his utmost to derive therefrom a certain amount of pleasure and satisfaction. If, for instance, a child dislikes his daily school as we know some children do, much better co-operation on his part can be secured if the teacher is able to show him the pleasure of achievement, the satisfaction of having really done something. The features in his work which really interest him can be emphasized. The day is coming when our school curriculum will be adjusted to the child, and less adjustment of the child to the curriculum."

The New York State Department of Education and the State Hospital Commission are developing a plan whereby the mental clinics of the state hospitals may be used for the examination of school children needing advice and treatment by a psychiatrist. Each clinic has a trained social worker who can co-operate with the teacher with a view to bringing about a better adjustment between the child and his environment.

". . . . I hope the time is not far distant when we shall be able to give the child a certain amount of instruction in the fundamentals of mental hygiene, including a certain amount of psychology and the study of the various factors which make up the personality, emphasizing and developing wholesome traits of character and suppressing those that are undesirable. The Horace Mann School of New York has already started in an experimental way a study of the personality of the school child. His various traits, habits and abilities are estimated as accurately as possible when he enters the school, and an effort made to develop those that are desirable and which make for efficiency and success.

"Herbert Spencer has defined life as a series of adjustments of inner relations to outer relations. If this be true, we must admit that the chief aim of education should be to develop in so far as possible, the adjusting capacity of the child. There is much to commend in modern methods of education as tending toward this end. Vocational guidance is finding out what the individual is fitted for, or, in other words, the environment to which he can hope to make a successful adjustment. Vocational training then steps in and develops his capacity for his chosen line of endeavor. We no longer believe that all boys and girls should have advanced academic training. Many mental breakdowns are a sad testimonial to the fact that all children cannot survive such training. There is still much to be learned in the field of mental hygiene and its application to the methods and principles of education. Mental health and mental efficiency will be best promoted when we have an effective and active co-operation between teacher, parent, school physician and social worker."

NOTES AND COMMENTS

California

Courses on Subnormal Children and Clinical Child Study, will be offered in the summer session of the University of California by J. E. Wallace Wallin, Director of the Psycho-Educational Clinic and Special Classes, in St. Louis, Missouri.

Kentucky

A bill to provide a training school and colony farm for feebleminded and epileptic persons has been passed by the Kentucky legislature.

The bill defines a feebleminded person as one "with a defect in mental development, which is due to causes operating at birth, or at an early age, and which is of such a degree that he is incapable therefrom of caring for himself or managing his affairs, and requires supervision, care, training, control or custody for his own welfare, or for the welfare of others, or of the community." An epileptic is defined as "a person who has epileptic attacks and is known to be losing his mental capacity as a result of these attacks, and is so distinctly enfeebled that he needs care and custody for his own welfare, or for the welfare of others, or of the community."

The object and purpose of this institution and the one which was established at Frankfort in 1860 is stated to be "the mental and physical training, the treatment and custody of feebleminded and epileptic persons, the promotion of their happiness and well-being and the study of mental deficiency."

The superintendent must be an expert in the care and management of the feebleminded, a graduate in medicine with at least two years' experience upon the medical staff of an institution for the care and treatment of feebleminded persons. His salary is not to exceed $3,000 a year. The first assistant shall be a competent physician and psychologist with at least two years' experience in the care of the feebleminded. The second assistant must be a competent farmer with experience in the supervision and employment of the feebleminded. The principal must be a trained educator with at least three years' experience in the control and education of the feebleminded, and may be either a man or woman. The principal is to have full charge of the educational and industrial employment of the inmates, excepting those in the farm colony.

The buildings are to be constructed upon the colony and cottage plan, and must provide for separation of the inmates by color and by sex, and as far as practicable the separation of epileptics from the non-epileptics. The farm colony is to be located upon a site to consist of at least 500 acres.

The bill provides for the commitment of feebleminded and epileptic persons of not less than six years of age.

Pauper imbeciles must be committed to this institution and not to the care of a "committee" as previously has been authorized by the "Kentucky Pauper Idiot Act." In case there is no room in the institution, pauper imbeciles may be committed to the care of a committee. Pauper imbeciles who have been previously committed to a committee and placed on the pension list for a five-year period may be still retained by the committee until the expiration of this period unless the committee voluntarily surrenders such guardianship. No pension shall be granted for a period beyond January 1st, 1921.

In accordance with this bill no feebleminded female under 45 years of age may be committed to any institution providing primarily for poor or infirm persons if there is room for such person in the institution for feebleminded. Aiding or abetting the marriage of any feebleminded person is declared to be unlawful.

All poor or indigent feebleminded or epileptic persons in the institution are to be supported by the state, and the costs incident to their transfer shall be a charge upon the state.

An appropriation of $25,000 a year for two years is provided; also a per capita payment of $75—the amount previously authorized for the care of pauper imbeciles when entrusted to guardians or committees. In addition to this, $190 a year is allowed for the maintenance of each inmate.

This bill is a result of a five months' survey of the feebleminded in Kentucky which was recently conducted by Dr. Thomas H. Haines for the National Committee for Mental Hygiene at the request of the State Commission on Provision for the Feebleminded, created in 1916 by legislative enactment. Dr. Haines' report has recently been published by the Commission and this bill embodies essentially the legislative recommendations made in the report.

Maryland

An appropriation of $80,000 has been approved by the Governor with which to equip the new psychopathic building at the Spring Grove State Hospital, Catonsville. This building has been offered to the Government to be used in the care and treatment of soldiers suffering from mental and nervous disorders.

Massachusetts

House Bill No. 1024, a bill to provide for the commitment of the feebleminded, reads as follows: "If the commission on mental diseases has reason to believe or receives a complaint in writing that there is a neglected, dangerous or uncontrolled feebleminded person in the community, it may cause an investigation by an agent of the commission to be made and may further cause the alleged feebleminded person to be examined by a physician to determine whether or not he is feebleminded and requires commitment. The commission, through its agent, may make application for commitment to the judge of probate in the county in which the feebleminded person is found. Unless the person sought to be committed is present at the time of the hearing, or the application is made by someone legally entitled to the custody of such person, notice of the application and of the time and place of hearing thereon shall be given to the person sought to be committed, and the order of commitment shall state what notice was given or the finding of facts which made notice unnecessary, and shall authorize custody of the person until he shall be discharged by order of a court or otherwise in accordance with law. The commission shall recommend that said person shall be committed to a school for the feebleminded, to an institution for defective delinquents or to the custody or supervision of the commission on mental diseases."

House Bill 1025 would authorize the director of the Bureau of Prisons, with the approval of the governor and council to lease and equip buildings and grounds for the care of defective delinquents until more permanent provision shall have been made in accordance with Chapter 595 of the Laws of 1911. This present bill carries an appropriation of $150,000 for expenses, including the cost of commitment, custody and support of defective delinquents.

House Bill 1026, now before the legislature, provides for the ascertaining of the mental condition of any person coming before the courts of the commonwealth. It allows the judge to request the Commission on Mental Diseases to have an examination made by a member of the medical staff of one of the state institutions under the supervision of the Commission.

A progressive measure and one that is arousing much interest in Massachusetts is House Bill 1320, now before the legislature. This bill, which aims to control venereal disease, carries the following budget:

Sixteen clinics, $1,000 per clinic	$16,000	
Printing and postage of venereal disease reports	1,200	
Two "follow-up" workers at $1,200 each	2,400	
Expenses, at $50 per month	1,200	
Framed placards advertising clinics	1,000	
Extra technician at Wassermann Laboratory	1,000	
Clerk in central office	750	
Above items indispensable to success of program		$23,550

Other very desirable items	$6,450
Extra educational literature	
Venereal disease exhibit	
Detection of quack advertising in violation of statute	
Clinical supervision of dispensaries, etc.	
	$30,000

The bill is urged by the State Department of Health and has the endorsement of Governor McCall. A vigorous attack on the problem is advocated not only for the purpose of protecting the soldier from the danger of this infection but also with a view of preventing the tremendous economic loss caused by this disease in the industrial and civil population.

The State Department of Health has been perfecting and carrying out plans for the control of these diseases for some time. Free laboratory facilities for their diagnosis became generally available in June, 1915, when the State Wassermann Laboratory was established. For the past two years the department has been experimenting with the manufacture of salvarsan and is now producing arsphenamine which is analogous to salvarsan, and is being manufactured at the rate of two thousand doses per day. In December the department declared these diseases to be reportable commencing February 1st, 1918. An extensive educational campaign is at present being carried on through lectures, lantern slides, pamphlets, etc. A health exhibit pointing out the menace of this disease is also being planned. Recently a bill was introduced by the department forbidding the sale or distribution of drugs for the cure or alleviation of gonorrhea or syphilis except upon the prescription of a physician. A plan has been made to establish sixteen clinics in thirteen of the largest centers of population in the state. These clinics will provide free, or at a little cost, facilities for the diagnosis and treatment of this disease.

The Church Home Society, a child-placing agency in Boston, has recently established a department of psychiatry. The plan of its work includes the following:

1. A study of the problem cases, that is, those cases which are failing to adjust to their present placement.
2. A study of all other cases under care as a routine measure for advice as to vocational or educational betterment and in order that records for every case may be on file.
3. A study of all new cases admitted.

Each child is considered in the light of his personal past history, his family history, his physical condition and his mental status. Standard intelligence tests, tests for special abilities and disabilities, and psychoanalytic or other therapeutic procedure are used when psychopathic tendencies are discovered. Record is made of the plan recommended for the child and through the visitor the plan of treatment is properly transmitted to the foster mother. Dr. Alberta S. B. Guibord is the psychiatrist in charge of this department of the work.

Michigan

Venereal diseases have been made reportable in Michigan. Patients with gonorrhea or syphilis are compelled to accept either carefully regulated treatment by a private physician or treatment at a public hospital. Severe penalties are provided for those who do not report regularly for treatment. Dr. Albert M. Barrett, director of the State Psychopathic Hospital, Ann Arbor, is co-operating with the Commission on Training Camp Activities and the military authorities at Camp Custer, Kalamazoo, in examining infected prostitutes and securing the proper segregation of those who are found to be psychopathic or feebleminded.

New York

The Hospital Development Commission, created in 1917 by legislative enactment, to study into the needs of the insane and feebleminded in the state, and to formulate a plan for the systematic upbuilding of the institutions, has recently submitted to the legislature a preliminary report in regard to the feebleminded.

The Commission recommends:

1. The establishment of a definite state policy by creating a board or commission to have the same powers over the feebleminded as the State Hospital Commission has over the insane.
2. The adoption of a state-wide commitment law for the feebleminded.
3. The taking of as complete a census as possible of all of the feebleminded in the state, obtaining all possible light on their family histories and surroundings.

After these steps have been taken it will be possible to determine the number of persons needing institutional care, the kinds of institutions needed, and the extent to which the state should go in dealing with the problem.

In its preliminary report to the legislature in regard to insanity, submitted on February 19, this Commission advocated among other measures, the early establishment of a 200-bed psychopathic hospital in New York City for incipient, acute or recent mental disorders. Great emphasis was also laid on the prevention of insanity through popular education and increasing the number of free clinics for mental and nervous disorders. This report urges the prompt increase of facilities in the metropolitan district to relieve the overcrowding in the hospitals by means of additional buildings at the Manhattan, Kings Park, Central Islip and the Brooklyn State Hospitals, and also the construction of a new hospital to accommodate 3,000 patients at Creedmoor in the outskirts of Brooklyn.

There are in New York State at present four institutions for the feebleminded. The Syracuse State Institution for Feebleminded Children was originally intended for those mental defectives susceptible of education. The Rome State Custodial Asylum was intended originally only for those of the lowest grade. Today it has all classes of feebleminded. The State Custodial Asylum for Feebleminded Women at Newark, was intended for women of child-bearing age, and Letchworth Village, the fourth institution, was originally intended as an institution for epileptics, but it is now used for the feebleminded of all degrees of mental defect.

These institutions differ in size, character and methods and they all operate independently under the separate law that created each. There is no state policy applied to them all, no state control, except fiscal, and no responsible body in the state for them all.

The Hospital Development Commission also believes that provision should be made for defective delinquents whose presence in the community is a great source of crime and expense. The defective delinquent is constantly coming into conflict with the law and the courts are perplexed where to send him. He does not respond to probation and if he is sent to an ordinary institution for the feebleminded, he is so intractable that he demoralizes the institution and receives no benefit. He is not susceptible to those influences which can be used successfully on normal inmates of a reformatory.

In accordance with one of these recommendations, a bill was recently introduced in the legislature to establish a commission for the care of the feebleminded. This Commission is to consist of the fiscal supervisor of state charities, the secretary of the state board of charities and one other member, who must be a physician, to be appointed by the governor with the consent of the Senate. The medical member is to be chairman of the commission.

This commission is to:

1. Take the census of all feebleminded in the state.
2. Provide accommodations in suitable institutions for such as require care and treatment.
3. Recommend to the legislature by February 1, 1919, a general commitment law for the feebleminded.
4. Establish farm and industrial colonies.
5. Administer the law relative to the care and treatment of the feebleminded.

This bill has been passed by both the Assembly and the Senate and has been approved by the Governor.

On January 16, the Utica State Hospital celebrated its seventy-fifth anniversary. This hospital is the first institution for the insane to be established in New York State. During the seventy-five years, it has treated a total of 28,105 patients.

The New York State Hospital Commission in its latest annual report, expressing the belief that nearly one half of all the cases of insanity are preventable, recommends the following definite steps toward their prevention.

1. Checking the excessive use of alcoholic liquors;
2. Checking the ravages of syphilis;
3. Informing the public more fully about mental diseases and teaching mental hygiene;
4. Measures to eliminate extreme poverty;
5. Extension of the out-patient department of the state hospitals with a greater number of free clinics for these disorders and field agents to look after incipient and convalescent cases.

North Carolina

A mental clinic is to be established at the State Hospital, Dix Hill, Raleigh, to which any person suffering from mental or nervous disorder may go for advice and treatment. This clinic, it is believed, will be of direct value to every social agency in the community. It will make possible the preventive treatment of mental and nervous diseases and the effecting of cures in the early stages.

Rhode Island

Chapter 1613 of the laws of 1918 authorizes the Penal and Charitable Commission of the state "to use every available means to ascertain the existence of any dangerous, infectious or contagious disease, including syphilis in the infectious stages and gonococcus infection, among the inmates, prisoners, patients and pupils of the institutions under its control, and to make examination of any of them suspected of having syphilis in the infectious stages or gonococcus infection, and immediately to investigate the source of such infection, and if ascertained, to report the same to the State Board of Health."

Every inmate, prisoner, patient or pupil thus afflicted must be immediately placed under medical treatment and, if it is necessary in the opinion of the attending physician, be isolated until danger of the contagion is past. If at the time for his discharge from the institution further isolation seems necessary, he may be detained until his discharge will not endanger public health.

The Commission is required to keep records of all cases of venereal diseases in these institutions, which records shall not be open to public inspection, and every effort must be made to keep secret the identity of the persons afflicted in so far as may be consistent with the enforcement of this law and the protection of public health.

South Carolina

The bill to establish a school for feebleminded in South Carolina, which passed the House in the 1917 session has recently been passed by the Senate and has been approved by the Governor. In this connection, the following abstract from the Governor's message to the General Assembly at the opening of the 1918 session may be of interest.

"Last year the House passed a bill to create a State custodial training school for the feebleminded. This bill is now on the calendar of the Senate, having been reported favorably from the Finance Committee last year. I earnestly hope the Senate will pass this bill early in its session, for, I believe, that body will not have before it a measure of greater importance.

"In addition to the convincing humanitarian and economic arguments that are offered in support of this measure, I urge your consideration of an astounding fact just revealed by a careful analysis of the official records of Camp Jackson.

"Up to December 13, a total of 18,642 conscripted men had been mustered into service there from North Carolina, South Carolina, and Florida. They had all passed the local exemption boards. But on re-examination by the medical authorities at Camp Jackson, 2,010 of these men were subsequently rejected, of whom 271, or 13.5 per cent., were rejected as being mentally defective. In fact, it was found that 14 out of every thousand of the 18,642 men mustered into service at Camp Jackson from these three States were rejected as being mentally defective. Of the South Carolinians, 13 out of every 1,000 were thus rejected. Advocates of the institution for the feebleminded have only claimed that three persons out of every 1,000 of the general population were feebleminded, but these official records indicate a proportion four times as great."

Virginia

Richmond has in its public schools, nineteen special classes. It is interesting to know that of these classes, one is for exceptionally bright pupils. The other classes, which are for children with mental defects, fall into two groups—those for borderline cases of which there are twelve classes, and those for morons of which there are six classes. In each of the former group there are twenty pupils, while the latter have fifteen pupils to a class. Each child is examined by a psychological examiner before he is placed in a special class and a social worker visits the homes of each of these pupils.

Public Health Reports, January 18, 1918, gives a summary of laws, ordinances and regulations presenting the important features of recent legislation in regard to the control of venereal diseases. Although this summary does not include all laws that have been passed on this subject, it analyzes representative laws and offers them in a convenient form for reference.

A Solvable Problem

"It is often interesting to see a person wake up after a long sleep—he makes such hard work of it, and takes so much time about it. It is equally interesting to see the state wake up after a long period of happy unconsciousness. The meeting at Lorimer Hall, Wednesday evening, under the auspices of the Massachusetts Society for Mental Hygiene was an expression of such an awakening. A few years ago, only a few experts knew that there were persons classified as 'defective delinquents,' but a hall full of people came together to hear the experts explain the subject.

"Defective delinquents are persons whose criminality is due in large measure to lack of mental development—whose minds are those of children while their bodies are those of men and women.

"Formerly, people were divided into two classes: the sane and the insane. The former were considered wholly responsible; the latter wholly irresponsible. Today we know that there are great numbers of people who have minds which are not normal, whose mental processes are not well-balanced, and whose misbehavior arises from this cause.

". . . Heretofore little attention has been given to the mental defectiveness of an offender, unless it reached a point which made it possible to classify him as insane, and, therefore, irresponsible for his acts."

"All others, regardless of their mentality, were punished like the normal person, many of them by imprisonment, usually for short terms, which yielded no profit to them or the state. The great majority of the 'rounders' are mentally defective, and are habitual offenders because of that. The insane are locked up permanently, or until they recover sanity. The semi-insane, even after scores of brief detentions, continue to incur brief jail sentences, what they did being the thing considered, rather than what they are.

"There is hope of the recovery of the man who has had a sound mind and has lost it. But for the feebleminded, whose mental development was arrested in childhood, there is little hope of material change. His mental boundaries are substantially fixed, and that should be considered when the state has to deal with his act of crime, especially if he repeats it.

"What shall be done with him? He does not respond to probation. He cannot. He does not belong in a prison, with other offenders. It is not fair to him, because he is incapable of learning by experience. What he needs is custodial care. In some cases there must be restraint, for he cannot be trusted, but in more cases he can be as well cared for without physical restraint, in farm institutions, where he can be employed.

"Our population in penal institutions is the smallest since 1874. There are hundreds of vacant places. Why should we not use the powers of transfer, assigned to the prison authorities as long ago as 1870, by which it is possible to classify offenders, putting this class into separate institutions, and dealing with them properly—not primitively, and not with the hope of reformation which we have for the normal, but with a view to the protection of the defective delinquent from himself, and the community from him?

"Fundamental in such a scheme would be the indeterminate sentence for minor offenders. This would make possible confinement of reasonable length for persons of this class, while the normal could, at the proper time, be released under suitable supervision."—Editorial, *Boston Herald*, January 13, 1918.

The Health Department of the Panama Canal reports that for the calendar year 1917, 12,543 Wassermann tests were taken of 9,561 persons. Of the white civil population, 1,516 males, 164 females, and 22 children were examined; 12.7 per cent of the males gave a positive reaction, and the percentages of the females and children were 12.2 and 22.7, respectively. Especially interesting were the results of the examination of 2,487 white soldiers, of whom only 10.9 per cent gave a positive reaction. Considered as a group, the blacks and mulattoes ranked highest, 30.6 per cent reacting positively. Of the 4,697 individuals composing the black and mulatto group, there were 3,774 males, 749 females and 174 children, whose percentages of positive Wassermann reactions were 32.8, 25.5, and 5.7, respectively. Thirteen Chinese males were examined, and 30.7 per cent gave positive reactions. Examinations were also made of 662 Spanish and white natives, divided as follows: males, 553; females, 96; children, 13. A positive reaction was obtained from 22.9 per cent of the males, while the females and children gave percentages of 15.6 and 15.3, respectively. In addition, Wassermann tests were made of 214 spinal fluids from as many individuals, and of these, 47, or 22.8 per cent, were positive.

MAINE'S MENTALLY DEFECTIVE AND NEEDS

"Although Maine is not the first State to begin a scientific study of her ne'er-do-wells and dependents to determine how best to provide for them, utilize their energy and prevent their increase she has not neglected them in either law or practice. The last Legislature amended the long standing statute prohibiting marriage of insane persons to include also the feebleminded, so that they are now prohibited from marrying.

"The Maine State Board of Charities and Corrections has indexed and tabulated information of approximately 12,000 dependents supported wholly or in part at public expense exclusive of the military dependents. About two thirds of these 12,000 are recipients of municipal charity. It is evident that the people of the State wish to care adequately for their dependents. In many cases they are doing so in their own homes without recourse to the public funds.

"Since true charity consists in supplying what is needed in a form to confer ultimately the maximum benefit to all, the mere giving of alms often falls far short of ideal accomplishment. And since the mentally defective are lacking in ideas and capacity for managing their affairs with discretion, it is of special importance in administering for the class in Maine or elsewhere that wise procedure be selected. Therefore, correct methods must first be devised for the most advantageous expenditure of the public funds later.

"Doubtless some cases of dependency due to mental defect could become partially at least self-supporting under especially adapted conditions, and doubtless, certain mental defectives could be trained to limited usefulness if the formative period of life be utilized for that purpose. Probably, a modification of the school life of certain backward children would result in benefit to the fully equipped scholars as well as to the mentally handicapped.

"The immediate problem of the Commission on Provision for the Feebleminded is, however, to reach an estimate of the number, varieties and location of the mentally inadequate cases the state has and to prevent any increase in their number. Before any measures for the improved economic condition of this class can be intelligently proposed, the class must be studied, its numbers found and their distribution noted.

"The interests of the mentally defective—and because of the existence of the class the interests of the whole community—have in very recent years begun to command the attention of thinking people of the most progressive of our states. The movement towards social uplift by improving the condition of the mentally defective, by elevating the standard of living of those whose standard is lowest has invariably taken the direction in its initial steps of studying these people and their environment. Each state has its own problem to solve, that is, the adaptation of its own best means to the accomplishment of its own specific ends. Therefore, Maine's first step in this widespread sociological movement is to study the needs of her mental defectives."—*Kennebec Journal*, Augusta, Maine, December 10, 1917.

American Association of Clinical Psychologists

The American Association of Clinical Psychologists was organized at Pittsburgh, on December 28, 1917. The membership includes persons holding the doctorate in psychology, who are engaged in the clinical practice of psychology in the United States. The forty-five charter members are chiefly directors of clinics, of bureaus of child welfare, of institutional laboratories; engaged in army service, as mental examiners of recruits and officers; or connected with courts, hospitals and schools.

The objects of the Association are to promote an *esprit de corps* among psychologists who have entered the practical field, to provide media for the communication of ideas, to aid in establishing definite standards of professional fitness for work in clinical psychology, and to encourage research in problems relating to mental hygiene and corrective education.

California Society for Mental Hygiene

The following committees of the California Society for Mental Hygiene are self-explanatory and give an idea of the extent of the Society's activities:

1. Committee on Public Meetings.
2. Committee on Mental Hygiene in National Defense.
3. Committee on the Commitment of the Insane.
4. Committee on the Establishment of a State Psychopathic Hospital.
5. Committee on the Study and Vocational Placement of Normal, Sub-normal and Super-normal Children.
6. Committee on the Advancement of the Medico-psychological Examination of Adult and Juvenile Delinquents and their Care and Treatment.
7. Committee on the Establishment of County Branches of the California Society for Mental Hygiene.
8. Committee on the After-care of the Insane.
9. Committee on Mental Hygiene Clinics.
10. Committee on Publicity.

In addition to the above, a committee on the care and treatment of persons addicted to the use of alcohol and drugs has also been proposed.

Massachusetts Society for Mental Hygiene

"In a recent issue of the Journal we made editorial comment upon the latest meeting of the Massachusetts Society for Mental Hygiene, which was held in Boston, on the general subject of shell shock. The Massachusetts Society for Mental Hygiene has now become a well-established and recognized organization, and has already accomplished work of a considerable amount of value. As an indication of the character of this work may be mentioned its publications, thirty-one in number, which include articles on Psychopathic Hospitals and Prophylaxis, by Dr. Frankwood E. Williams; on The Menace of Syphilis to the Clean-Living Public, by Dr. J. Harper Blaisdell; on The Burden of Feeblemindedness, by Dr. Walter E. Fernald; on The Relation of Syphilis to Mental Disease, by Dr. Samuel T. Orton; and on The After-Care of Mental Patients, by Dr. Henry P. Frost. The Society also has a corps of about thirty speakers, men and women, who are authorities on the various phases of mental hygiene, who will, without charge, deliver public addresses on such subjects as the following: Preventable Psychoses and How to Prevent Them, by Dr. E. Stanley Abbot; Mental Disease and Crime, by Dr. V. V. Anderson; The Defective Child and the Schools, by Miss Frances E. Cheney; The Practical Phases of Inebriety, by Dr. Irwin H. Neff; and Mental Pitfalls of Adolescence, by Dr. Henry R. Stedman.

"The Society, as an agency of preventive medicine, merits professional recognition for the work which it has already accomplished, and should be able to go on to accomplish still more of value as its methods become developed."—Editorial, *The Boston Medical and Surgical Journal*, January 31, 1918.

THE SCOPE OF MENTAL HYGIENE

"It is a fallacy to view the subject of mental hygiene as a separate scientific entity distinct from general hygiene. It would, perhaps, be better to look upon mental hygiene as the initial and essential step toward general hygiene. Certainly it is the pivot around which all notions of hygiene must revolve. It is essentially necessary to understand and to carry out the principles of mental hygiene in order to develop the kind of mind that will be receptive to the dictates of general hygienic principles. With the development and the conservation of the mind, whether as a matter of course in evolution or as the result of positive effort in study and research, has come the eradication of diseases previously scourges of mankind, and which, undoubtedly, will be followed by still further progress in this direction. But whether it is a question of progress in general or in mental hygiene, large results must come from the efforts of the entire community, rather than by individual effort.

"The first necessity in mental hygiene, as in general hygiene, is the exclusion of foreign sources of mental disease and the isolation and segregation of those found in a given community. In a measure, even mental disease is 'contagious' indirectly from the influence that association with mental cases has on immature minds, but perhaps more directly by the tendency to transmit mental disease to the offspring. Moreover, there are certain diseases and conditions, almost entirely preventable, which seem to have a very marked tendency to produce mental disease in the person concerned and then in the offspring by hereditary transmission. In this respect, alcohol and syphilis are, of course, the most important factors. The prevention of alcoholism and syphilis would be the greatest factors in the promotion of mental hygiene and in the conservation of the mind. It is estimated that 70% of the mental conditions are hereditary in nature. This would seem to indicate that, in spite of the enormous number of insane and defective, very few of them are accidental infections, so to say, but are, most of them, due to bad ancestry.

"Of those not traceable to heredity, the cause of mental disturbance can be found in the lack of attention in the very young to such conditions as environment, food, exercise, preventable illness, etc.,—the same conditions, practically, that officiate in the causation of physical conditions. Besides, the impressionistic condition of early life makes it essential that only those ideas be allowed to appear before the child that will arouse healthful thoughts and actions. The depressing, the maudlin and the exciting must be religiously kept from the immature mind. Instead, their places must be taken up by healthful play, exercise, amusement, reading. The mind, as the body, must be carefully guarded from trauma of any kind. The mind must be exercised but not injured. When the child has a bad heredity these elements must receive especial attention in order to anticipate injury, just as a frail child must be more carefully guarded than the normal. Suitable occupation must be determined early, and proper vocational training given in order to prevent economic failure and the depressing effect it has on the mind. Vocational guidance, based on mental and physical capacity and inclination should be the foundation of the future industrial life of the child. No opportunity must be overlooked to encourage and to educate the younger generation in wholesome interests and wholesome thoughts, and to discourage laziness, dreaming and introspection.

"Much of the incidence of mental disease and defect can be reduced by proper education, even when the heredity of the individual is bad; more of it can be prevented by the eradication of preventable diseases and abuses, and much more by segregating and preventing marriage and propagation by defectives and those suffering from alcohol, syphilis, and like conditions, and finally by a more rigid exclusion of alien sources of disease, disease tendency, and inferiority."—Editorial, *Boston Medical and Surgical Journal*, March 21, 1918.

A SOCIAL SERVICE BUREAU FOR SING SING PRISON

A meeting was held in New York City at the residence of Mr. Adolph Lewisohn, on March 1, 1918, for the purpose of launching a bureau of social service in co-operation with Sing Sing Prison. The object of this new bureau, as set forth in its by-laws, is to provide relief for needy dependents of prisoners, to furnish employment to discharged prisoners, and to assist in other ways in there rehabilitation. This movement is a natural outgrowth of the efforts of the Psychiatric Clinic at Sing Sing in its relation to the men who leave prison to return into the community.

The work of the Psychiatric Clinic with the incoming prisoners has led to the formulation of plans for the reorganization of penal procedure in the state. The realization of this programme, however, must await the construction of the central clearing station for the new Sing Sing, and is at best a matter of time. But even under the most progressive and intelligent administration of the prison system as such, the purposes for which it exists could not be adequately accomplished without the supplementary machinery of an after-care service.

In establishing this service, it is hoped that its reaction upon the prison itself will be to hasten the progress of its socialization. In addition to the direct practical advantages to the prisoner and to the community to be derived from the application of definite knowledge of individuals and the problems of their rehabilitation, substantial gains are expected from this movement in the field of criminologic research.

It is particularly fortunate that the Social Service Bureau is organically affiliated with the Prison since the Warden is the president of this organization, and its close relation to the Psychiatric Clinic will insure a rational, scientific management and administration of its affairs. Dr. Bernard Glueck, Director of the Psychiatric Clinic, has been elected Chairman of the Executive Committee of the Bureau, and Drs. L. Pierce Clark and William L. Russell, members of its Advisory Committee.

In diverting considerable of the Clinic's attention and resources to the work of the Social Service Bureau, opportunity will be had to study scientifically the behavior and personality of inmates beyond the period of their confinement, and to observe and record the conditions of their progress or the causes of their failure in maintaining themselves at large as useful citizens.

THE NATIONAL CONFERENCE OF SOCIAL WORK

The forty-fifth annual session of the National Conference of Social Work, which will be held at Kansas City, Missouri, May 15 to 22, will be one of absorbing interest to the medical profession. Some of the topics to be presented are Care of Convalescents; Medical Inspection of Schools; Public Health Nursing; Hospital Social Service; Nutrition; Health Centers; A National Program of Infant Welfare; National Salvage of the Handicapped; Preparing the Soldier Incapacitated by Nervous or Mental Diseases for Return to Civil Life; Types of After-the-War Problems; The Care of Feebleminded; Results and Significance of Mental Hygiene Work in the Army; and Adequate Legislation for Mental Disorders.

The National Conference of Social Work is the one great nation-wide medium of exchange between individual social, health, prison, recreation, industrial, relief and other workers and between organizations and communities all over the United States and Canada interested in the "how and why" of community well-being. The meeting and the program are both most interesting and timely.

Dr. Frankwood E. Williams, Associate Medical Director of the National Committee for Mental Hygiene, is Chairman of the Section on

Mental Hygiene. The general topic of this section will be Preparing the Community to Receive Soldiers Invalided because of Nervous or Mental Disease. At the general session Dr. Williams will discuss the Results and Significance to the Community of Mental Hygiene Work in the Army. Major Richard H. Hutchings, M.R.C., will discuss the Preparations Now Being Made by the Surgeon General for the Return to Civil Life of Soldiers Incapacitated by Nervous or Mental Disease. The first section meeting will be devoted to the subject of War Neuroses (Shell Shock) after the War, and papers will be read on the Types of Problems to be Met; Institutional Preparation; and Extra-institutional Preparation. At a second section meeting, the situation created by the presence in the community of a large number of men suffering from war neuroses will be considered. A summary of the legislation in the various states on the subject of insanity will be read and a constructive program of legislation proposed. A second paper will summarize the present state of the law in regard to the feebleminded with a constructive program.

The large number of mental defectives being excluded from the Army and returned to their home states makes it necessary for the states to prepare to meet the problem of feeblemindedness more adequately than they have in the past. Two sessions will therefore be devoted to outlining a program to meet this need. Such a program should include a survey of the situation in any given state, facilities for proper diagnosis, registration of the feebleminded, instruction, supervision and segregation. Papers will be read upon each of these subjects. The final meeting of the Mental Hygiene Section will be a combined meeting with the Section on Delinquence and Correction, Mrs. Jessie D. Hodder, Chairman. At this session, Dr. Bernard Glueck, Chairman of the Sub-Committee on Causes of Crime, will read a report of that committee and papers will be presented on Studies in Personality among the Feebleminded and A State System of Care of the Problem of Crime.

Special Classes in Public Schools of New York State

The New York State Department of Education is developing plans to put into effect next fall the Lockwood law, enacted in 1917, which will provide for special classes for backward and defective children in the public schools throughout the state. The law extends to all parts of the state a system already thoroughly established in New York City and in several of the larger cities of the state. There are at present in New York no less than 28 cities, among which are Albany, Binghamton, Buffalo, New York, Rochester, Schenectady and Syracuse, maintaining special classes for feebleminded and backward children. These classes will give a basis for procedure. The law provides for a census within the present year of all school children who are three years or more retarded in mental development, and requires the organization of special classes of not more than fifteen pupils each in every district in which there are ten or more retarded children.

Dr. Thomas E. Finegan, Deputy Commissioner of Education, recently called a conference of educators and mental hygiene workers in New York City to discuss plans for taking the census. These plans are now developing. The Department of Education has asked the legislature for an appropriation to secure an able man to supervise the enumeration of school children needing special instruction, and to direct the organization of the classes.

The importance of special classes and the extension of the work to all parts of the state has become generally recognized. It has become increasingly evident that the place in which feeblemindedness should be recognized is the public school. The establishment of facilities there for identifying backward and feebleminded children, and establishing separate classes for them is an integral step in the provision of adequate custodial institutions by the state—a matter which has aroused widespread public interest, and is being carefully studied by the Hospital Development Commission.

Public interest has been aroused in New York State to the gravity of the problem of feeblemindedness, and different state departments are attacking the problem from different standpoints. There is an increasing co-ordination of efforts of these departments. The State Board of Charities, the State Hospital Commission, the Hospital Development Commission in charge respectively of the institutions for the feebleminded, the institutions for the insane, and of formulating a policy for the development of these institutions, and the departments governing them, are heartily in sympathy with the plans of the State Department of Education, and working with it. There is hope that the Compulsory Education Law will be amended so as to make obligatory the education of the defective child. The effectiveness of enforcing such an alteration in the law, however, is quite dependent upon the state's ability to provide special classes to train these children. The Department has invited the co-operation of private agencies interested in the problem, and has recently held conferences with representatives of organizations as the New York Committee on Feeblemindedness, The National Committee for Mental Hygiene, and the supervisors of special class work in different cities in New York as well as the normal schools that are training teachers for special classes.

PSYCHOPATHIC HOSPITALS

"The humane care of the insane and the scientific treatment of mental disease are the supplementary and interdependent principles upon which every state hospital system must be based. To cure patients as soon as possible is the most economical as well as the most scientific and humane way of treating them, and to take advantage of every reasonable possibility of cure is the only course for the state to pursue when it makes itself responsible for the life and welfare of one of its citizens. Much is now done, but much is done too late. The most critical period of mental disease in acute cases comes in the beginning. This is the time when the patient is ordinarily most susceptible to remedial treatment, but in this state the patient is likely to spend these days, while the legal procedure of commitment is being gone through, in an almshouse or a department of an almshouse institution known as a pavilion for the alleged insane, or even in a station house or a jail.

"Psychopathic hospitals should be located in populous portions of the cities where they are established, in order that they may be accessible to the people, as are other special hospitals. They should have out-door departments, through which patients can be seen in their homes, and dispensaries, to which they can come for consultation in the incipient stages of nervous and mental disease. They should be organized like other hospitals, public and private, general and special, with staffs of internes selected by competitive examination from among the best graduates of the medical colleges, attending and consulting physicians and surgeons, selected from among the most eminent specialists in the state, well-equipped laboratories for research work, and auditoriums for the instruction of students in the too-little studied subject of psychiatry. At such hospitals patients should be received as at other general or special hospitals at any time of the day or night as emergency cases. Many would doubtless be discharged as cured in the course of a few days or weeks, and would never be committed to a regular state hospital. Other cases, such as those of slow progress, convalescents, chronic cases and incurables would be transferred to other state hospitals as soon as the nature of their disease was thoroughly understood.

"Many incidental advantages would accrue from the establishment of such institutions. They would do away with the use of almshouses, station houses and the like as places of detention for the alleged insane. They would command the gratuitous services of the best trained neurologists and alienists in the state as visiting physicians. Through their connection with the medical colleges they would contribute to the education of young physicians, and so would raise the standard of general professional knowledge of psychiatry throughout the country. Through their dispensary and out-patient departments they would make possible the preventive treatment of nervous and mental cases, before actual insanity could be alleged, and the remedial treatment of the insane in the earliest stages of their disease. The benefit to the people of the state through the establishment of these proposed hospitals would be almost incalculable.

"The chief arguments in favor of the establishment of psychopathic hospitals may be summarized as follows:

(1) Such hospitals are an integral part of a complete state hospital system, and without it the system goes lame.

(2) Such hospitals will help check the present rapid increase in the number of the insane by heading off the stream at its source.

(3) Such hospitals, by preventing and curing cases of mental disease in incipient and in early stages, will prevent their becoming chronic insane patients, and will save the state the expense of continuous care of chronic cases for a long term of years in regular state hospitals.

(4) These hospitals, by receiving and caring for recent and acute cases of insanity, will diminish the numbers annually committed to the other state hospitals, and so will relieve the overcrowding in these hospitals."

From a Memorandum Submitted to the Hospital Development Commission by the Committee on Mental Hygiene of the New York State Charities Aid Association.

THE PAROLE SYSTEM OF NEW YORK STATE HOSPITALS

CAN PAROLES BE INCREASED?

It would seem at first sight that the matter of granting parole must be a purely medical question and that the number paroled could not be altered for the sake of any economic advantage.

In one sense this is true. When we consider the first factor of parole—the patient's mental condition, we realize that no amount of desire on the part of the state or the hospital can bring about more recoveries among the insane, except as adequate medical and nursing care, and equipment tend to produce such a result. The mental condition of the patient is a medical question and cannot be altered because the taxpayer desires it.

The mental condition, however, is not the only element to be considered. Parole is also determined to a large extent by the possibility of securing suitable environment outside the hospital. For the recovered case, the mental condition is decisive. But many paroles are possible without complete recovery—dependent entirely upon the ability to place the patient under favorable conditions.

One of the prime factors in parole is obviously environmental. The hospital that wishes to increase its paroles must learn to control this factor. The state hospital cannot afford to be medical only; it must be social and educational, as well—and that from an economic as much as from a humanitarian standpoint.

Control over the patient's mental state is exerted within very narrow limits but there is no barrier to the continued growth and development of control over the environmental conditions. It is here then, if anywhere, that increase of the number on parole, and consequent decrease of the cost of maintenance of the insane, is to be looked for.

THE RELATION OF THE OUT-PATIENT DEPARTMENT TO THE PAROLE SYSTEM

I. The Effect of the Mental Clinics

(A) *On the Hospital*

1. They provide a means whereby the hospital can supply medical supervision to its patients even when they live at a distance.

2. They provide an inconspicuous place to which sensitive patients are willing to come when they would hesitate to return to the hospital.

3. By giving parole patients an opportunity to see regularly and frequently a physician who understands them, the hospital is able to keep patients on parole who would otherwise have to return.

4. They furnish the hospital with its best weapon for combating prejudice and superstition in the district.

5. They are the greatest means the hospital has for carrying on educational and preventive work; the only method of decreasing the number of commitments.

(B) *On the Hospital Physician*

1. They furnish a new and stimulating field of work for the hospital physician.

2. In so far as they undertake to do preventive work, they bring the hospital physician in contact with the beginning stages of mental disease and with the milder forms which rarely reach the hospital.

3. They bring the physician face to face with the concrete social problems which have to be solved in connection with the mentally ill.

4. They make the physician realize the importance of the hospital as a social force.

5. They make the physician realize the importance of the hospital as a preventive medical agency.

(C) *On the Community*

1. They are of direct value to every social agency in the community, since every such agency has problems involving mental conditions.

2. They are means of bringing the community into friendly relationship with the hospital which thus definitely gives its services to aid the community in its mental health problem.

3. In cities, they make the psychiatrist accessible to the middle-class citizen who can not afford to consult the high-priced specialist and in consequence goes without advice or treatment for mental disease, or resorts to quacks.

4. In the country districts, they constitute as a rule the first and only source of diagnosis and treatment of mental conditions.

5. They provide the most promising instrument for removing popular prejudice against the state hospitals and for raising the general level of intelligence in the state with regard to mental disease.

6. They give to the community its first real opportunity to organize preventive mental health work.

II. How is Social Service Helping to Increase Opportunities for Parole?

1. The field worker gives definite reliable information as to just what conditions a patient is being sent.

2. Often by some thought and effort she is able to adjust those conditions to the needs of the patient.

3. The field worker makes the transition from hospital to home easier. She is the connecting link between the sheltered life of the hospital and the more difficult life outside. She supplies the encouragement and support which the patient requires until his adjustment to home conditions is made.

4. The field worker often prevents a discouraged patient from giving up and returning to the hospital before he has made a fair trial.

5. The field worker often persuades a discouraged family to bear with the patient a little longer until a difficult period is over.

6. The field worker is the greatest hope the hospital has of persuading an unwilling, selfish, or fearful family to take up the care of a patient who can well be cared for at home.

7. The field worker is often the deciding factor in parole, when a relative or friend who would otherwise be afraid to assume full responsibility is quite willing to give the patient a trial with the interest and supervision of some one from the hospital.

8. The field worker makes the hospital human and understandable to a community. Where she is known personally to many families, where she works in touch with the nurse, the school teacher and the health officer, her influence with a family in that district who are considering taking home a patient is like that of a personal friend.

9. Often the possibility of getting employment is the decisive factor in parole. Here the field worker is indispensable. It is not only a question of finding employment but of finding suitable employment and an employer who is willing to work with the hospital for the interests of the patient.

10. The field worker goes to the patient's home at a moment's notice and adjusts difficulties or investigates complaints which, without her, would necessitate the return of the patient to the hospital.

11. Every time a field worker keeps on parole a patient who would otherwise return to the hospital; every time she succeeds in placing a patient who would otherwise have to remain in the hospital, she is doing not only a humane but an economic service to the state and is helping to decrease the public expense of maintaining the insane.

GROWTH OF THE PAROLE SYSTEM

The parole system of the state hospitals has shown a substantial growth during the past several years. The average daily number of patients on parole from the thirteen civil state hospitals during the past fiscal year was 1,504 as compared with 1,346 in 1916, 1,280 in 1915, 1,141 in 1914, 978 in 1913, 905 in 1912, 783 in 1911.

Following is a table containing a comparative statement of the average number of patients on parole from each of the hospitals for the years 1913–1917:

Average Number on Parole	*1913*	*1914*	*1915*	*1916*	*1917*
Binghamton	49	54	54	55	59
Brooklyn	30	31	38	27	36
Buffalo	75	82	82	74	83
Central Islip	170	217	238	303	334
Gowanda	18	26	31	22	37
Hudson River	55	58	70	108	111
Kings Park	131	173	238	243	224
Manhattan	136	146	144	145	192
Middletown	40	43	52	57	67
Mohansic	2	1	1	..	..
Rochester	70	66	81	77	95
St. Lawrence	93	92	78	79	92
Utica	62	99	109	93	101
Willard	47	53	64	63	73
Total	978	1,141	1,280	1,346	1,504

The number of patients actually on parole on June 30, 1917, is given in the following table:

Binghamton	69
Brooklyn	26
Buffalo	91
Central Islip	285
Gowanda	25
Hudson River	90
Kings Park	265
Manhattan	325
Middletown	72
Rochester	104
St. Lawrence	51
Utica	104
Willard	52
Total	1,595

The increase in the number of patients on parole the past few years is undoubtedly due in considerable part to employment of the field workers and to the establishment of additional clinics by many of the hospitals. Many superintendents report that the knowledge on the part of the staff that a patient will be supervised, makes it possible for them to try out patients whom they would otherwise hesitate to parole.

If merely the financial benefits of the parole system were considered, the value of the system would at once be apparent. The average cost of maintaining a patient in a state hospital is about $220 a year. Thus during the past year the state saved approximately $330,880 by having an average of 1,504 patients on parole. Furthermore, each patient on parole makes room for a new patient. If it had been necessary to erect new buildings to house an equal number of patients there would have been a heavy additional expenditure.

The growth and development of the parole system depends largely upon its proper supervision and increasing the effectiveness of the out-patient clinic work. Like the colony system in the institutions for the feebleminded, it offers the most practical method yet suggested of reducing the state budget for the maintenance of the insane.

From a Memorandum Submitted to the Hospital Development Commission by the Committee on Mental Hygiene of the New York State Charities Aid Association.

MILITARY NEURO-PSYCHIATRY

The following promotions have recently been made in the Neuro-Psychiatric service: from Lieutenant Colonel to Colonel, Pearce Bailey; from Captain to Major, Sanger Brown II, Frank D. Fernau, A. S. Pendleton, Horace Phillips, Mortimer W. Raynor, John T. Sample, Charles E. Sisson, Robert P. Smith, Edwin G. Zabriskie; and from Lieutenant to Captain, Geoffrey C. H. Burns, R. M. Chambers, Ambrose F. Dowd, Roy Haber, Harry R. Hoffman, W. H. Holmes, John J. Hughes, W. C. Kalloch, George A. MacIver, Thomas F. Niel, John D. O'Brien, and Robert F. Zimmerman.

A precedent calculated to encourage enlistment in the Army Medical Corps on the part of psychiatrists who have families dependent upon them, was recently taken by the State of New York when it settled upon a policy of providing maintenance for the families of the physicians and other officers in its state hospitals while the men are in military service.

The Attorney General of New York has held that the maintenance of state hospital officers and their families is a part of their compensation, and that therefore the law providing for the state to make up the difference between the civil and the military compensation of the men contemplates providing maintenance for the dependents of the men while they are absent on military duty.

In order that the psychiatrists and neurologists of the country might be kept in closer touch with the development of the work and the needs of the Division of Psychiatry and Neurology of the Army, the Executive Committee of The National Committee for Mental Hygiene has invited representatives of the various neurological and psychiatrical societies of the country to nominate members for appointment to membership on the War Work Committee. The following appointments have been made: Dr. Isadore Abrahamson, New York City, Section on Neurology, New York Academy of Medicine; Dr. Charles R. Ball, St. Paul, Minnesota Neurological Society; Dr. Siegfried Block, of Brooklyn, New York, Brooklyn Society of Neurology and Psychiatry; Dr. Max H. Bochroch, Philadelphia, Philadelphia Neurological Society; Dr. Edmund A. Christian, Pontiac, Michigan, Detroit Society of Psychiatry and Neurology; Dr. Archibald Church, Chicago, Section on Neurology, American Medical Association; Dr. W. R. Dunton, Towson, Maryland, Maryland Psychiatric Society; Dr. Herman H. Hoppe, Cincinnati, Cincinnati Neurological Society; Dr. Herbert B. Howard, Boston, Boston Society of Psychiatry and Neurology; Dr. Edward E. Mayer, Pittsburg, Pittsburg Neurological Society; Dr. Charles K. Mills, Philadelphia, Philadelphia Psychiatric Society.

The following have also been added to the membership of the War Work Committee: Dr. E. Bates Block, of Atlanta, Georgia; Dr. Edward N. Brush, Superintendent of Sheppard and Enoch Pratt Hospital, Towson, Maryland; Dr. Henry Hun, Albany, New York; Dr. George A. Moleen, Denver, Colorado; Dr. J. W. Putnam, Buffalo, New York; Miss Florence M. Rhett, Chairman, Mental Hygiene Committee, State Charities Aid Association, New York City; Dr. H. Douglas Singer, State Alienist and Director of State Psychopathic Institute, Kankakee, Illinois; and Dr. Beverly Tucker, Richmond, Virginia.

One of the most important changes recently made in the Medical Corps of the Army, is the assignment of a psychiatrist to each tactical Division as Divisional Psychiatrist. The duties of the Divisional Psychiatrist have been outlined as follows:

1. To examine or cause to be examined all cases of mental and nervous diseases occurring in the command.

2. To be available for all special neuro-psychiatric examining boards which may be convened from time to time for the purpose of examining the command.

3. To ask for the assignment of regimental surgeons to assist in the neuro-psychiatric examination of recruits. This latter largely for the purpose of instruction of regimental surgeons.

4. To supervise the making of all reports of examinations in his specialty and the forwarding of them to the Surgeon General.

5. To see to it that the recommendations of neuro-psychiatric examiners are promptly prepared for forwarding to general disability boards.

6. To hold from time to time brief informal conferences with regimental surgeons and company commanders in relation to the general subject of military neuro-psychiatry.

7. In cantonments, to be available for consultation with medical officers stationed at base hospitals.

8. To visit frequently regimental infirmaries and, whenever invited, the nervous and mental wards of base hospitals.

9. To co-operate with Judge Advocates for the purpose of establishing in every Division a method of treatment of delinquents similar to that in successful operation at the Leavenworth Barracks. As a result

of this method many cases of mental disease may be counted upon to be discovered and recommendations to be made that the charges be dropped and S. C. D. Board convened or that the case be tried and if a sentence and findings be imposed, that the findings of the court be approved (including discharge), and the confinement be remitted.

10. To be consulted in reference to service battalions should such service battalions be established in connection with depot brigades or base hospitals.

11. To co-operate with psychological examiners, and if practicable to arrange for psychiatric and psychological surveys of troops to take place at the same time and place.

In accordance with this decision the following men have been appointed as Divisional Psychiatrists: Capt. Chester C. Beckley, Attending Psychiatrist, Industrial School for Girls, Lancaster, Massachusetts; Major L. Vernon Briggs, formerly Secretary, Massachusetts State Board of Insanity; Capt. Cyrus B. Craig, Associate Physician, Neurological Institute, New York; Major Frank D. Ferneau, Visiting Physician at the Toledo State Hospital, Toledo, Ohio; Lieut. Howard M. Francisco, Assistant Physician and Pathologist at the Central Hospital for Insane, Nashville, Tennessee; Lieut. John Cecil George, of the Orchard Spring Sanitarium, Dayton, Ohio, formerly Assistant Physician, Columbus and Dayton State Hospitals; Lieut. Leizer Grimberg, of New York City, physician at the Neurological Institute; Capt. Thomas J. Heldt, Assistant Physician, New York Psychiatric Institute, Ward's Island; Capt. Harry R. Hoffman, Attending Psychiatrist, Psychopathic Hospital, Chicago, and instructor in nervous and mental diseases, Chicago Polyclinic; Capt. William H. Holmes, head of Department of Clinical Pathology, Northwestern University, Chicago, Illinois, formerly Assistant Physician, Kankakee State Hospital, and of the Illinois State Psychopathic Institute; Capt. John J. Hughes, of Mt. Vernon, New York, formerly Assistant Physician, Matteawan State Hospital; Major Frank Hutchins, Professor of Mental and Nervous diseases, Indiana University, Indianapolis; Capt. Dudley C. Kalloch, Assistant Psychiatrist, Psychiatric Clinic, Sing Sing Prison, Ossining, New York; Capt. George A. MacIver, of Boston, Massachusetts, formerly Assistant Physician, Worcester State Hospital; Capt. John D. O'Brien, formerly Assistant Physician, Massillon State Hospital, Ohio, and McLean Hospital, Waverley, Massachusetts; Capt. Walter J. Otis, Assistant Physician, McLean Hospital, Waverley, Mass.; Major Arthur S. Pendleton, of Raleigh, North Carolina, formerly Clinical Pathologist to State Hospital; Major Horace Phillips, formerly Assistant Physician, State Hospital for Insane, Warren, Pennsylvania, and Philadelphia Hospital for the Insane; Major Mortimer W. Raynor, Clinical Director of the Manhattan State Hospital, and formerly Director, Psychiatric Clinic, Blackwell's Island; Lieut. Thomas James Riach, Assistant Physician, Kankakee State Hospital, Kankakee, Illinois; Major John T. Sample, of Saginaw, Michigan, formerly Assistant, Neurological Department, Johns Hopkins University; Capt. Francis M. Shockley, Psychiatrist at the Westchester County Penitentiary of New York, and formerly Assistant Physician at the Government Hospital for the Insane, Washington, and Assistant Psychiatrist at the Psychiatric Clinic, Sing Sing Prison; Major Charles E. Sisson, Assistant Superintendent, Norwalk State Hospital, California; Major Robert Percy Smith, Neurologist, Kings County Hospital, Seattle, Washington, formerly Associate Professor of Nervous and Mental Diseases, College of Physicians and Surgeons, Baltimore; Major Charles W. Stone, Assistant Professor of Nervous Diseases, Western Reserve University, Cleveland, Ohio; Capt. Edward Adam Strecker, Assistant Physician, Pennsylvania Hospital, Department for Nervous and Mental Diseases, Philadelphia; Capt. Otto G. Wiedman, of Hartford, Connecticut, Assistant Physician, Hartford Dispensary, and Consulting Psychiatrist, Mental Hygiene Clinic, Connecticut Society for Mental Hygiene; Lieut. Philip Work, of Denver, formerly Assistant Physician, Woodcroft Hospital, Pueblo, Colorado; Capt. Harry J. Worthing, Assistant Physician, St. Lawrence State Hospital, Ogdensburg, New York; Major Edwin G. Zabriskie, Associate Physician, Neurological Institute, New York City; and Capt. Robert F. Zimmerman, formerly psychiatrist, Psychopathic Laboratory, Police Department, New York City.

The Federal Government is prepared to provide care and treatment for the military insane in whom the insanity is incurred in the line of duty in the present war. But it has been held that the care of the military insane in whom the mental disease existed prior to enlistment, or was for other reasons not contracted in the line of duty, should be assumed by the several states. To assure absolute fairness in deciding responsibility for the expense, most careful attention is being given in each instance to the question of line of duty. At the request of the Surgeon General letters have been addressed to the proper authorities of the several states urging them to co-operate by receiving officers and soldiers of the above class, the Federal Government to transport and deliver the men to any point or points indicated by the state authorities.

The following states have already signified their willingness to co-operate: Alabama, Arizona, Arkansas, Colorado, Connecticut, Florida, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

Arrangements have not as yet been completed with New Jersey, South Dakota, and Wyoming, and no reply has as yet been received from California, Georgia, Kentucky and Louisiana.

BOOK REVIEWS

Applied Psychology. By H. L. Hollingworth and A. T. Poffenberger, Jr. New York: D. Appleton and Company, 1917. 337 p.

The authors seek in this book to bring together in a systematic form material dealing with the various ways in which psychology is coming into more intimate touch with the practical conditions of social life. Psychology, in view of its methods and of its special material, is able to contribute much to the solution of many problems of practical importance. It is now beginning to demonstrate its economic value, and even to assert it at times in a somewhat aggressive form. In a series of chapters the application of psychological methods and principles to problems of business management, of industrial organization, of economic distribution and of legal procedure is discussed. While there is little that is very novel in these chapters, they give in a readable form a general survey of certain aims which are going to become of great importance in relation to the welfare of society.

In the early part of the book, where the authors deal with certain conditions of the efficiency of the working individual, there is much material which is perhaps too familiar to be required in a book of this type; and it may be questioned whether much of the material included in the chapter on the influence of sex and age is relevant to a book on applied psychology. Similarly, the influence on working efficiency of ventilation, of the weather, etc., is perhaps more suited for an ordinary textbook of psychology or physiology than for one of applied psychology. The chapter on drugs and stimulants might also be considered out of place in this work.

On the whole, the book should prove a useful addition to the somewhat limited number of books dealing with practical demands of life from the standpoint of the psychological student; and although it does not contain much that is new, it can be recommended for its sober judgment on many of the problems with which it deals.

C. Macfie Campbell.

Handicaps of Childhood. By H. Addington Bruce. New York: Dodd, Mead & Company, 1917. 310 p.

The author cites in the first chapter, dealing with *Mental Backwardness*, various cases which under special treatment largely overcame their mental retardation. "It may be considered as definitely established today that the vast majority of cases of mental backwardness are the result, not of organic brain defects, not of true feeblemindedness, but of remedial physical conditions or faulty training in the home. It may be considered as established that even seemingly incurable cases will often yield to expert treatment." Chapter II, points out that the only child unduly pampered by overindulgent parents "is peculiarly liable to fall a victim to hysteria, neruasthenia, and other serious functional nervous disorders, and is prone to be conceited, jealous and envious; begrudging the happiness of friends and acquaintances, he is often shunned and disliked." The facts given in this chapter are based on the careful findings of several investigators. Chapter III deals with *The Child Who Sulks*, whose sulkiness is often regarded as an indication of an unpleasant disposition calling for stern disciplinary measures, rather than the result of conditions for which the child is not to blame and more likely to be indicative of nervous or mental stress, as well as physical maladjustments. The author gives various suggestions to help remove the cause and start the child on the path to healthful emotional control. Chapters IV to VII deal with *Jealousy, Selfishness, Bashfulness and Indecision* and *Stammering*. Their cause is pointed out in specific cases, and also the necessity of wise training in childhood. The remaining chapters give an interesting account of *Fairy Tales that Handicap* and *Night Terrors*.

Unfortunately the period of sketchy, anecdotal and incomplete analysis of a particular handicap of childhood has passed for the proper instruction of the general public, as it has long ago for the medical profession. The consideration of the peculiar defects of childhood as enunciated in this book is too incomplete to warrant its being included in the best up-to-date helps to the more intelligent class of parents. To handle such problems properly, it has been proved more and more conclusively that in a book of this character the author himself must necessarily go exhaustively into and analyze some definite, concrete data; he may then give such comments as he cares to make upon the facts. Knowledge at first hand is essential. There is no doubt that the general text is very readable, and that it was illuminating to a number of the indiscriminate public at the time of its previous publication, as the author indicates that the text is a collection of various sketches of his which appeared in current magazines and periodicals.

L. PIERCE CLARK.

THE PSYCHOLOGY OF SPECIAL ABILITIES AND DISABILITIES. By Augusta F. Bronner. Boston: Little, Brown & Company, 1917. 264 p.

Those who have been interested in the psychological approach to problems of maladjustment have come to expect sound, dependable, and enlightening contributions on this subject from Dr. Healy and his coworkers, as a matter of course. Dr. Bronner's timely book adds much force to the conviction that such expectations are fully justified. The book constitutes another highly successful effort to draw constructive and valuable conclusions concerning normal mentation from the study of anomalous types. But it is much more than this. It points out more incisively than any other work with which we are familiar, the necessity for individualization in any effort to understand and treat intelligently case-problems of social unadjustment or maladjustment. Not that the futility of handling the maladjusted in large anonymous masses is escaping the attention of the better informed and the better intentioned workers in this field. On the contrary, the cry for this is heard on all sides. But a survey of current discussions on methods of definition of deviations from normality, especially the persistent quibbling over the precise lines of demarcation between normal intelligence and intellectual deficiency, makes one doubt whether we have fully grasped the meaning of individualization. The danger is great for mistaking its real meaning for a mere substitution of one formula for another. We are brought no nearer, for instance, to a helpful solution of problems of misbehavior by merely substituting psychological names for legal ones, by the mere assertion that a criminal is feebleminded. That much that is vital remains untold when one stops by merely calling an individual feebleminded, is forcibly demonstrated by Dr. Bronner's discussion of special abilities in the defectives. Equally hampering is an attitude towards the problem which ignores the special disabilities of those who do measure up, nevertheless, to the various standards of normality. The truth, that it is always possible that men will lose sight of the end and become fanatic about the means, has again had ample demonstration in the history of psychometry. Although it is an excellent means for the definition of mental ability and capacity, it has been taken in many quarters as the very end of psychological procedure. But in the practical administration of the living objects of psychometric definition much more than the mere labeling with the term "feebleminded" is needed if constructive results are to be had. It seems to the reviewer that Dr. Bronner's book meets in a very substantial measure this need. It points the way to a real approach in matters of vocational guidance, and should be of inestimable value to the teacher, not only on account of the very lucid and informing discussion of important theoretical phases of education, but also because of the many case records of concrete problems. Case 8, which is discussed on page 61, is of especial interest because it demonstrates the social value inherent in a better understanding of the individual.

The book is introduced by a lucid statement of the problem which is essentially an attempt to define to what extent careful psychological study of the individual may help toward remedying individual problems of maladjustment. It then discusses methods of diagnosis, both direct and differential. In Chapter IV, where present educational tendencies are discussed, a plea is made for a greater effort at differentiation and individualization, so that intelligent allowances may be made in the school curriculum for special disabilities, and advantage be taken of special abilities. The succeeding four chapters are devoted to a discussion of special types of defects, and this is followed by a chapter on special abilities with general mental subnormality. The concluding chapter is followed by an appendix of the test records of the cases given in the text. A careful reading of the book is recommended to everyone interested in problems of education and behavior.

BERNARD GLUECK.

THE MENTAL CAPACITY OF THE AMERICAN NEGRO. By Marion J. Mayo. New York: The Science Press, 1913. 70 p. (Archives of Psychology, edited by R. S. Woodworth, no. 28, November 1913.)

The problem of this investigation is the determination by a comparison of school marks of the relative efficiency in scholarship of the white and colored pupils in the high schools of the city of New York. The study was based upon a statistical treatment of school marks. With all the defects connected with such material, the writer maintains that the school mark is a real measure of the pupil's ability. The children studied were selected with great care and were all chosen from mixed schools in order that the conditions for comparison might be more favorable. The white pupils for comparison were chosen at random and included several different nationalities—English, German, Irish, Italians and Jews. Care was taken to control conditions as much as possible. The white students enrolled in the high schools are about four times as many as the colored in proportion to the population. Thus the colored pupils represent a closer selection from the entire population than do the whites.

In his concluding chapter, the author gives a brief survey of our present knowledge in regard to the relative mental capacity of different races. As regards the negro and the white man the studies of the brains have given conflicting evidence. Mr. Bean of Johns Hopkins University studied the brains of 103 negroes and 49 American whites and reports that the brain weight of the negro is demonstrably smaller than that of the Caucasian and that the size and shape of the front of the brain are different in the two races, being smaller and more angular in the negro, that the convolutions of the Caucasian brain are more elaborate, the fissures deeper, the relative amount of white matter greater, and the front end of the corpus callosum made up of association fibres, relatively greater. On the other hand, Dr. Mall in another investigation at Johns Hopkins University finds no such positive conclusions, but rather that on the average the relative percentage of the frontal lobe is the same in both races, and he says that "any claim that the negro brain is more simian or fetal than that of the white is entirely unwarranted."

Probably the conservative statement by Dr. Mall quoted by the author represents the present status of the question. He says: "For the present, the crudeness of our method will not permit us to determine anatomical characters due to race, sex or genius, which if they exist are completely masked by the large number of marked individual variations. . . . Arguments for differences due to race, sex and genius will henceforward need to be based upon new data, really scientifically treated and not upon the older statements."

The results of this investigation, however, indicated no statistical grounds for the view of racial mental equality, but pointed clearly to a measurable degree of mental difference. To quote the author's own words, the chief findings were as follows: "The two racial groups considered showed mental differences that were important and constant. In every subject of study the white group attained a higher average of scholarship. In every year of school work, the white group passed in a much larger percentage of studies. The colored group is always more advanced in age than the white group of corresponding grade. The colored group require from a term to a year longer to complete the grammar school course than do the whites. All these important facts point in the direction of a difference in race psychology."

WILLIAM H. BURNHAM.

THE EXCEPTIONAL CHILD. By Maximilian P. E. Groszmann. New York: Charles Scribner's Sons, 1917. 764 p.

The main part of the book is the work of Dr. Groszmann, but pages 562 to 703 consist of a medical symposium by a group of physicians in which a variety of topics are dealt with in a summary manner. This symposium is an indication of the rather ambitious nature of the work.

In his general outlook on the problems of childhood the author, as a rule, shows good judgment, although one might take exception to some of the detailed views expressed. It would be rather unfortunate if the following statement were to be taken seriously by any readers: "As a rule we allow premature fatigue to interfere with the activity of our children. . . . We do not work the children intensely enough." There is little basis of actual physiological fact for the following daring speculation (page 134): "Who will venture to deny the possibility that by proper stimulation we may vastly increase the number of functioning cells, and thus of the potentialities of thought and of motor activity?"

The book is well illustrated and written in an agreeable style, but is somewhat discursive and not well proportioned; pages 248 to 371 are devoted to the question of standardization of tests, a subject which at this period need hardly be gone into in so great detail. The case material which is presented throughout the book adds considerably to its value.

C. MACFIE CAMPBELL.

NERVES. By David Fraser Harris, M.D. London: Williams and Norgate, 1913. 256 p.

This book is an exposition, limited as to its space and illustration, of the capabilities and peculiarities of the nervous system, more particularly of those regions whose activities are not associated with the rousing of consciousness. The student of the nervous system will find that the general principles are discussed with some thoroughness; he may even find explained certain neural activities which the systematic textbooks pass over lightly.

The first chapter is entitled *How the Nerves Work*. Various chapters deal with nerve fibres, nerve impulses, reflex actions, nerve energy, fatigue and repair of the nervous system. The book also contains a glossary and a bibliography.

The title *Nerves* implies a treatise upon different forms of hysteria and psychoneuroses, but the book is, however, a popular anatomical and physiological understanding of the make-up and function of the nervous system. As such it is very well done, and clearly and intelligently written. Unfortunately in the last few pages an attempt is made to correlate these anatomical and physiological data as a more or less direct explanation of the phenomena of sleep, the psychoneuroses of neurasthenia, morbid fears, etc., etc. It is more or less generally acknowledged at the present time that the neuroses and psychoses are best understood, even by the lay individual, by psychological rather than anatomical approach, as a correlation of structural mechanisms of the brain proper can hardly be considered comprehensible in the understanding of mental processes.

L. PIERCE CLARK.

THE EDUCATIONAL BEARINGS OF MODERN PSYCHOLOGY. By Christabel M. Meredith. Boston: Houghton, Mifflin Company, n. d. 143 p.

The aim of this book is to present some of the results of recent psychological investigation significant for education. The doctrine is for the most part sound and based largely on the psychology of the natural instincts and impulses. The aim of the educator is to train pupils "to behave in a certain way when faced by certain stimuli"; that is, in certain situations. There are three factors in the instinctive process, the stimulus, the emotion accompanying the perception of the stimulus, and the reaction. For the individual whose instincts are aroused the emotion overshadows everything, but the stimulus and the reaction offer the means for training.

Some instincts fortunately tend to check and counteract each other, and hence can be legitimately used by the educator. We can appeal to curiosity or the learning instinct to overcome anger and sometimes fear. If ways of counteracting instinctive tendencies cannot be found, often the best method of procedure is to avoid stimulating it as much as possible. But in any case the teacher should recognize that the child is prompted to action chiefly by its possession of instinctive tendencies. The teacher must work with and not against nature. It is difficult to thwart or suppress instinct. It is much easier to guide it by intelligent stimulation.

Our knowledge of instincts in animals suggests that the best and most effective development can come only by the exercise and satisfaction of all the instincts as far as possible. Some educators believe that the best environment for children up to twelve is to give as much as possible the free life of primitive conditions out-of-doors. While this is impracticable to any great extent for the majority of pupils, the teacher should sympathize with this point of view and provide some legitimate outlet for the wilder and more primitive instincts. These instincts may at any rate be partially satisfied under civilized conditions; and the boy whose curiosity and love of adventure finds an outlet in the study of birds and animal life is naturally and more intelligently developed than the boy who always has a stone in his hands to throw at any living creature. In a word, "The practical outcome of all this study of instinct in children is the need for greater freedom in school life," and for rational guidance of children's behavior by appropriate stimulation. On this basis the writer considers also mental growth, the development of habits, and memory, and discusses adolescence.

This book is quite as valuable for the student of psychiatry as for the student of education. Its simple teachings are important for mental health as well as for efficient education. It is carefully written and usually free from error. One loose statement in the chapter on adolescence is unfortunate. The writer says, on page 127, "roughly speaking for English children we may expect adolescence to begin about the age of twelve or thirteen." Assuming that there is no great difference between the development of English children and American children this statement is fairly correct for girls; but with boys the advent of adolescence occurs about two years later and, as shown by studies of Crampton, there are great individual differences. Only in a few cases are boys pubescent at the age of twelve or thirteen. On the whole, the book is an excellent primer and gives a good introduction to the subject of educational psychology.

WILLIAM H. BURNHAM.

PROBLEMS OF SUBNORMALITY. By J. E. Wallace Wallin. Yonkers: World Book Company, 1917.

The book is written around four fundamental propositions. First, the need of development of adequate methods of differential diagnosis of subnormality; second, the need of providing proper educational treatment in accordance with this diagnosis; third, organization of adequate systems of after-care, after-guidance and control; and fourth, the development of preventative measures.

Probably more stress is laid upon the question of accurate diagnosis than upon any other phase of the problem. The author rightly insists upon the necessity of adequate training for those who would attempt mental diagnosis; although the reviewer would hardly agree that the required training laid down in the book is adequate for this purpose. The author says, "Mental diagnosis should be in the hands of the psychologist. To be sure, the physical diagnosis and necessary medical treatment are matters for the physician; but the psychologist should diagnose the degree of mental deficiency found—if any—and should determine the cause of it, distinguish the various psychic, adolescent deviations which resemble psychoses, but which are not truly psychotic in character, and prescribe the needed pedagogical and social treatment, having in mind all the facts bearing on the case."

Certainly there are reasonable and just grounds to question the ability of the well-trained psychologist to handle this field, particularly when we think of the innumerable problems arising for differential diagnosis that are essentially medical in nature, and particularly when we consider in adults the various psychotic conditions, and deteriorations from alcohol, syphilis, physical disease, etc. The author has set quite a task for the psychologist.

The establishment of psychological clinics in connection with public school systems, courts and such is advocated. The author believes that the director of such a clinic should be a technically trained educator and psychologist.

In the opening chapter, the author traces the changing attitude towards the subnormal from the early times when these unfortunates were regarded with indifference, contempt and aversion, up to the modern enlightened and scientific period.

Few persons who are feebleminded ever carry their school work beyond the third grade; few feebleminded persons ever reach the Binet-Simon mental age of ten years—so the author thinks. He believes that from five to ten per cent of the inmates in our state institutions for the feebleminded are not actually feebleminded. He feels that the special classes for defectives in the public schools are made the dumping grounds for all kinds of pedagogical misfits and social ne'er-do-wells, that the vast majority of the pupils reported in the retardation census are not feebleminded, and do not belong in such classes, but should be placed in ungraded classes. One fifth of the elementary pupils throughout the United States are retarded one year or more in their school work. Much of the high rating indicating the immense prevalence of feeblemindedness is due to wrong methods of diagnosis. Amateurs have posed as authorities on this subject, equipped with little more than the Binet-Simon scale. They have made sweeping findings that, according to the author, are valueless. He believes that the twelve-year dead line for feeblemindedness has no sound basis; he is more inclined to make ten years the limit, but clearly insists—and rightly—that a definite Binet age-limit is rather dangerous to use by itself. "Reliable mental diagnosis of children can not be made simply by following the arbitrary quantitative standards of intelligence retardation which have been in general use since 1910. A rule-of-thumb method is dangerous." He rightly insists that there are many aspects and clinical phases of mental deviations which are not elicited by the administration of a series of controlled tests.

"As a consequence of all of this, the percentage of feeblemindedness in schools, institutions, courts and prisons has been greatly over estimated because false standards have been used." The author feels that the term feeblemindedness should be sharply delimited; it should be drawn at the point where intelligence is so deficient that an older adolescent or adult is just barely unable to make a living, cannot maintain an independent existence at the simplest form of work afforded by the community.

Chapter three deals with the general principles and facts to be recognized in the organization of work for mentally and pedagogically retarded children. The chapter consists of a discussion of some twenty declarations and resolutions drawn up by the author, together with a questionnaire which was sent to the supervisors and superintendents in public schools of some sixteen large cities of this country. A group of tables indicating replies is included.

In the fourth chapter, the educational and social bearings of the problem of the feebleminded are discussed. Three basic phases are dealt with—first, the obligation of society to identify and register the feebleminded; second, the obligation to educate properly and train the feebleminded children; and third, the obligation to provide continuous oversight and supervision of the feebleminded. All these are the functions of the public school system in the opinion of the author.

Chapter five discusses the problem of epilepsy in its psychological, educational, social and medical relations. The handling of the medical aspect is, however, quite inadequate.

The last chapter is a treatise on the hygiene of eugenic generation. Especial attention is called to the seriousness of venereal disease and alcohol in causing race deterioration.

There is considerable repetition in the book, with too much attention given to the historical phase of the subject, and too little attention to the recent contributions, particularly from the field of psychiatry. The pathology of the feebleminded is hardly mentioned, and the endocrinological aspects of the subject are almost entirely neglected. Much consideration is given to the educational aspects of the problem, and a great deal of attention to the Binet testers who are posing as authorities.

The attitude of the author towards the problem of feeblemindedness is quite clear from the following quotation: "Feeblemindedness is not a disease process, but a defect. The feebleminded person is not a sick person; inasmuch as simple feeblemindedness is not amenable to medication or surgical interference; inasmuch as feeblemindedness is an incurable condition, therefore, the medical problem for the feebleminded differs in no essential from the medical problem affecting any type of child. Therefore, the care and improvement of the feebleminded is primarily an educational and social problem."

The book contributes little to the scientific study of feeblemindedness.

V. V. ANDERSON.

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DIRECTORY OF SOCIETIES AND COMMITTEES FOR MENTAL HYGIENE

(Listed in the order of their origin)

The Connecticut Society for Mental Hygiene

(Organized, May, 1908)

39 Church Street, New Haven, Conn.
Miss V. M. Macdonald, Secretary
Miss Ines Newman, Associate Secretary

The National Committee for Mental Hygiene, Inc.

(Organized, February, 1909)

50 Union Square, New York City
Dr. Thomas W. Salmon, Medical Director
Dr. Frankwood E. Williams, Associate Medical Director
Clifford W. Beers, Secretary

The Illinois Society for Mental Hygiene

(Organized, July, 1909)

824 South Halsted Street, Chicago, Ill.
Miss Elnora E. Thomson, Executive Secretary
Mrs. Eleanor C. Slagle, Director of Occupations

Committee on Mental Hygiene of The New York State Charities Aid Association

(Organized, May, 1910; an outgrowth of an After-care Committee, organized in 1906)

105 East 22nd Street, New York City
George A. Hastings, Executive Secretary
Miss Jessie Taft, Social Service Director

The Massachusetts Society for Mental Hygiene

(Organized, January, 1913)

1132 Kimball Building, 18 Tremont Street, Boston, Mass.
Dr. Charles E. Thompson, Secretary

The Mental Hygiene Society of Maryland

(Organized, March, 1913; an outgrowth of an After-care Committee, organized in 1911)

401 Garrett Building, Baltimore, Md.
Dr. Charles B. Thompson, Executive Secretary

The Committee on Mental Hygiene of the Public Charities Association of Pennsylvania

(Organized, March, 1913)

Empire Building, Philadelphia, Pa.
Kenneth L. M. Pray, Acting Secretary

The North Carolina Society for Mental Hygiene

(Organized, December, 1913)

Dr. Albert Anderson, Secretary, Raleigh, N. C.

The Dayton Mental Hygiene Committee

(Organized, March, 1914)

Address: Mrs. J. Franz Dolina, or Mr. A. G. Knebel, Dayton, Ohio.

The Society for Mental Hygiene of the District of Columbia

(Organized, April, 1915)

Dr. D. Percy Hickling, Secretary
1305 Rhode Island Avenue, Washington, D. C.

The Alabama Society for Mental Hygiene

(Organized, April, 1915)

Dr. W. D. Partlow, Secretary, Tuscaloosa, Ala.

The Louisiana Society for Mental Hygiene

(Organized, May, 1915)

Dr. Maud Loeber, Secretary
1729 Marengo Street, New Orleans, La.

The California Society for Mental Hygiene

(Organized, June, 1915)

Miss Julia George, Secretary
638 Phelan Building, San Francisco, Cal.

The Rhode Island Society for Mental Hygiene

(Organized, March, 1916)

Dr. Frederick J. Farnell, Secretary
335 Angell Street, Providence, R. I.

The Ohio Society for Mental Hygiene

(Organized, May, 1916)

Dr. Thomas H. Haines, Secretary
Ninth and Oak Streets, Columbus, Ohio.

The Tennessee Society for Mental Hygiene

(Organized, May, 1916)

C. C. Menzler, Secretary
Nashville, Tenn.

The Missouri Society for Mental Hygiene

(Organized, May, 1916)

Dr. Francis M. Barnes, Jr., Secretary
Humbolt Building, St. Louis, Mo.

The Indiana Society for Mental Hygiene

(Organized, October, 1916)

Frank D. Loomis, Secretary
88 Baldwin Block, Indianapolis

The Iowa Society for Mental Hygiene

(Organized, March, 1917)

Dr. Gershom H. Hill
Des Moines, Iowa

The Virginia Society for Mental Hygiene

(Organized, March, 1917)

Dr. William F. Drewry
Petersburg, Va.

Harvard University
Department of Social Ethics

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Current Bibliography .... Mabel W. Brown

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MENTAL HYGIENE

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MENTAL HYGIENE will aim to bring dependable information to everyone whose interest or whose work brings him into contact with mental problems. Writers of authority will present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public will be republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology will be presented and discussed in as non-technical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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MENTAL HYGIENE

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CARE AND DISPOSITION OF THE MILITARY INSANE*

PEARCE BAILEY,
Colonel, Medical Corps, N. A.

IMMEDIATELY upon the declaration of war it devolved upon the medical department of the Army to reconsider the existing provisions for the military insane. It was evident that the facilities for the care and treatment, and the regulations controlling disposition, which had sufficed for a small Army, would not meet the enormously enlarged program. All over the United States, to say nothing of France, beds would have to be made ready. Means would have to be devised for the prompt evacuation of these troublesome cases from the active medical services; and, as a man once insane cannot be counted a reliable soldier for general service, all unnecessary delays in the matter of discharge must be obviated. Finally, any system would not be satisfactory which did not cut down transportation to a minimum. The problem was approached in the following ways:

1. Elimination at the source.
2. Care and treatment in military hospitals.
3. Care and treatment in civil hospitals.
4. Evacuation: Army regulations.

1. ELIMINATION AT THE SOURCE

The systematic examinations for the detection of the existence of nervous and mental disease and defect, established in the first place with the object of eliminating from the fighting forces unstable and unreliable individuals, resulted, as will be shown later in this article, in a much smaller number of insane requiring hospital care than had been originally expected.

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* Publication approved by the Surgeon General, United States Army.

From the beginning of the mobilization these examinations were carried on at Officers Training Camps, Cantonments, Recruit Depot Posts, and in fact at all points where registrants or volunteers were being mustered into service. By October, 1917, there were approximately 200 officers engaged in this work, mostly Medical Reserve Corps Officers and mostly of considerable civil experience in neurology and psychiatry.

Two chief methods of examination were employed—that of general surveys and that of referred cases.

By the first method, the whole command passes in groups before the special officers, and, on the basis of a brief conversation, observation and examination for tremors, changed reflexes, etc., an estimate is formed as to whether or not further investigation is desirable. An examiner can handle from 100 to 150 men a day in this way without difficulty; and during rush times must handle more.

By the method of referred cases the general survey is omitted and only such cases as are referred by regimental surgeons, company commanders, etc., are examined. This latter method is only reliable when the training period is reasonably long, so that idiosyncrasies, defects, etc., have time to come to the surface under the stress of service.

Co-operation with the psychologists commissioned in the Sanitary Corps, while considered highly desirable and now being carried out, was not possible during the early days of the mobilization, and results obtained by them are not referred to in this article.

Cases recommended for rejection or discharge as a result of these examinations are referred to the surgeon or to a disability board. It has never been considered advisable to recommend that disability boards be composed exclusively of psychiatrists. Composed as they have been of general medical officers, these latter have acquired a better appreciation of the methods and significance of neuropsychiatry and the resulting discharges have not been considered as due to the enthusiasm of "specialists." A large proportion of the recommendations made by neuro-psychiatrists have been approved by the disability boards and later by the commanding officers.

Disqualifications based solely on the existence of nervous or mental disease or defect have been found in from one and one-half to five per cent, varying with the organization examined. It is believed that most of them would not have been recognized by general medical officers, as they often existed in men physically robust. In many instances also, notably of psychoses and epilepsy, a skillfully elicited and well confirmed history would establish a disability which was not demonstrable or even at first denied at the time of the examination.

Nearly three fourths of the recommendations for discharge made by the neuro-psychiatric examiners were for conditions primarily mental, as opposed to organic disease or defect of the nervous system.

Among the first 13,481 recommendations there were

Mental Defect	4,737 cases, or	35.1%
Epilepsy	1,729 cases, or	12.8%
Psychoneuroses	1,542 cases, or	11.4%
Constitutional Psychopathic State	1,239 cases, or	9.2%
Dementia Praecox	800 cases, or	5.9%
Alcoholism	759 cases, or	5.6%
Manic Depressive	257 cases, or	1.9%
General Paresis	237 cases, or	1.8%

It will be observed that of this large group of recommendations for discharge, 83.7 per cent represented a class of case which is apt at some time or other to require custodial care; and that the elimination at the source of soldiers afflicted with any of the foregoing conditions is an essential part of the program of the care of the military insane, to say nothing of its help in the forming of a strong army.

2. CARE AND TREATMENT IN MILITARY HOSPITALS

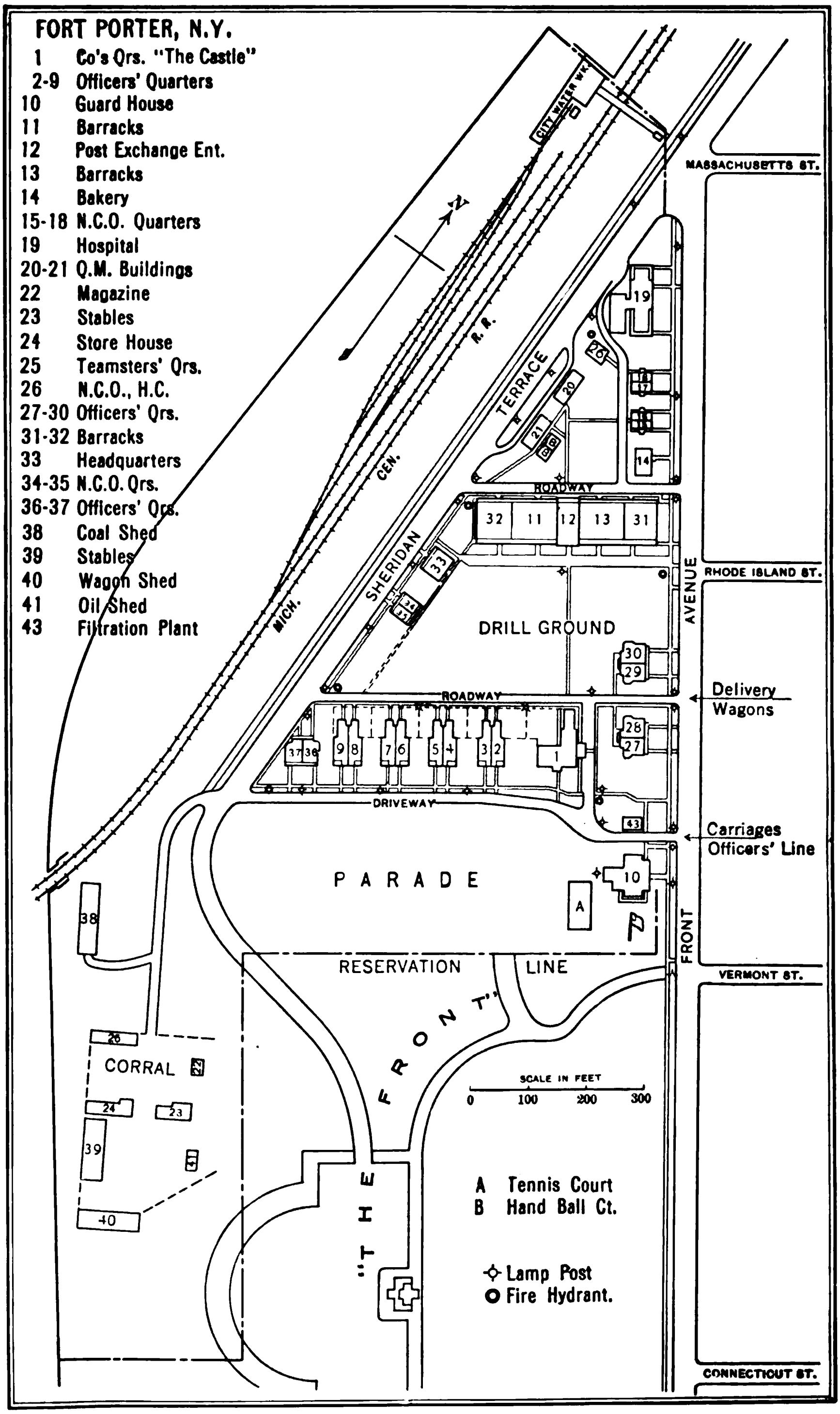
All cantonments were provided with neuro-psychiatric hospital units, which consisted of one or two buildings especially designed and equipped to care for nervous and mental patients. The plan included wards and private rooms for officers, day rooms, detention rooms, diet kitchen, etc. The special equipment, not supplied at all stations, consisted of continuous baths, sprays with control tables and different electro-therapeutic apparatus. The commissioned personnel for these wards was designated by the Surgeon General's Office, Division of Neurology and Psychiatry, and the enlisted personnel was made up, as far as possible, from former attendants in state hospitals. Many of these latter were inducted into the service for this purpose.

However, the above accomodations did not meet the needs of the situation, either as to the numbers of patients or as to the general plan. Delays incidental to transfer and discharge caused the beds to be occupied too long by patients who were awaiting discharge, to the exclusion of the actually ill. It was also difficult to maintain an adequate personnel with the requisite experience at so many small units. It was therefore decided to consider these units as places of reception and brief detention only, where patients would remain long enough to receive orders for transfer for treatment elsewhere or to be discharged from the Army.

So it soon became evident that larger and more permanent mental establishments, still of the military service, would have to be provided. These were intended to subserve the functions of psychopathic hospitals in every sense of that term; that is, they were to receive and treat for periods of time, varying from few weeks to a few months, all cases of acute psychoses occurring in both officers and enlisted men. The Letterman General Hospital in San Francisco, being on the return route from the Philippines, had always had special provision of this kind. It was merely decided to enlarge this principle and to put into operation special wards which would be on the return route from the camps. The location most desirable for them was evidently in the centers of dense military population, and this was arranged as nearly as was compatible with the economical utilization of existing facilities. In addition to the wards at Letterman Hospital, there have been established the following *Centers* for the care and treatment of the insane at:

Fort Sam Houston, San Antonio, Texas.
Fort McPherson, General Hospital No. 6, Atlanta, Ga.
Fort Des Moines, Des Moines, Iowa.
Walter Reed General Hospital, Washington, D. C.
Fort Porter, General Hospital No. 4, Buffalo, N. Y.

The first four of these are all of the same type of construction, namely R. 1 and R. 2 buildings of the cantonment plan. In these two buildings are the electric and hydro-therapeutic equipment, single rooms, day rooms, wards for disturbed patients, etc. When necessary the accommodations may be easily increased by the addition of buildings of the ordinary hospital type. For example, there are with capacity of about 100 patients, four buildings in all at Fort McPherson and at Walter Reed Hospital. Fort Sam Houston is not yet in full operation, although it probably


FORT PORTER, N.Y.
1 Co's Qrs. "The Castle"
2-9 Officers' Quarters
10 Guard House
11 Barracks
12 Post Exchange Ent.
13 Barracks
14 Bakery
15-18 N.C.O. Quarters
19 Hospital
20-21 Q.M. Buildings
22 Magazine
23 Stables
24 Store House
25 Teamsters' Qrs.
26 N.C.O., H.C.
27-30 Officers' Qrs.
31-32 Barracks
33 Headquarters
34-35 N.C.O. Qrs.
36-37 Officers' Qrs.
38 Coal Shed
39 Stables
40 Wagon Shed
41 Oil Shed
43 Filtration Plant
N
CITY WATER WKS.
MICH. CEN. R.R.
SHERIDAN
TERRACE
ROADWAY
DRILL GROUND
ROADWAY
DRIVEWAY
PARADE
RESERVATION LINE
"THE FRONT"
CORRAL
MASSACHUSETTS ST.
RHODE ISLAND ST.
VERMONT ST.
CONNECTICUT ST.
AVENUE
FRONT
Delivery Wagons
Carriages Officers' Line
SCALE IN FEET
0
100
200
300
A Tennis Court
B Hand Ball Ct.
Lamp Post
Fire Hydrant.

will be before this article is published. The hospitals at Fort Sam Houston and Fort Des Moines are under the jurisdiction of the Southern and Central Departments respectively, but the others are general hospitals, and so are under the exclusive authority of the Surgeon General.

The former Army Post at Fort Porter is now General Hospital No. 4. The post buildings have been converted at moderate expense to accommodate 155 patients. It is the only Army hospital so far set aside for the exclusive use of the insane. It was primarily intended for expeditionary cases only, but home service cases are constantly being sent there. It is contemplated to establish another set of nervous and mental wards for expeditionary cases nearer the port. This seems advisable both for the purpose of having a greater margin of available beds in case of emergency, and also because many returned cases can thus be given directly into the care of their friends at the port of debarkation, and will be spared the unnecessary journey to Buffalo.

For the Letterman General Hospital, San Francisco, which for years has received the mental cases returned from the Philippines —it is to be remembered that troops serving in foreign countries even in peace times, have a markedly higher insanity rate than troops serving at home—and for the whole Western Department, there is now under construction an additional permanent building to be used as psychopathic wards with a capacity of 50 beds.

The commissioned personnel for these special wards and centers has been selected from Reserve Corps Officers, who have had wide clinical and administrative experience in state or other hospitals for the insane. Most of the enlisted personnel were, before the war, state hospital attendants. Some of these were inducted into the service for the purpose of entering the Medical Corps, with assignment to this special variety of nursing, and others were transferred from other services into the medical service. The National Committee for Mental Hygiene has been of great service in sending to the Surgeon General the names of these experienced attendants. In many of the wards, the head nurse is a trained woman nurse, with special experience, and a member of the Army Nurse Corps.

The sites of the various centers were selected from their being as nearly as possible central points in areas of dense military population. The transfers naturally are from the point where the soldier was, to the nearest center where beds are available. In general it works out something as follows:

Letterman General Hospital:

Will receive patients from the Philippines and from the Pacific coast generally, e.g., from Camps Kearney, Fremont and Lewis; from General Hospital 20, from Fort Douglas, Utah, etc.

Fort Sam Houston:

Will receive patients from the Southern Department generally, e.g., from Camps Cody, Doniphan, Bowie, MacArthur, Travis, Logan, Beauregard, from Forts Bliss, Sill, Worth, Bayard, etc.

Fort McPherson:

Will receive patients from Camps McClellan, Sheridan, Shelby, Wheeler, Gordon, Hancock, Jackson, Wadsworth, Sevier, Greene; from General Hospitals Nos. 14, 18, 19, etc.

Fort Des Moines:

Will receive patients from Camps Funston, Dodge and Grant; from Jefferson Barracks; from Forts D. A. Russell, Riley, Leavenworth, Snelling, etc.

Port Porter:

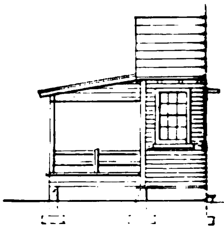
Will receive patients from, in addition to those from all points included in the port of embarkation, General Hospitals Nos. 1, 5 and 16; from Camps Custer, Devens and Upton, and from other posts in the neighborhood.

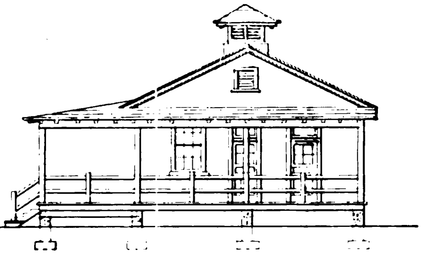
Walter Reed General Hospital:

Will receive patients from Camps Dix, Meade, Lee, A. A. Humphreys, Sherman, Taylor; from Washington and Columbus Barracks; from General Hospitals Nos. 2, 3, 7 and 11.

The transfer to the special psychiatric center is effected as follows: The patient whose symptoms are considered as requiring special observation and treatment is ordered for that purpose to the hospital designated. The orders are obtained from the Adjutant General through the Surgeon General, and initiated by the commanding officer at the point from which the patient is removed. Thus the soldier, be he officer or private, presenting the symptoms of insanity, is transferred not as an insane person, but as any other patient. In this way, the Army regulations concerning the disposition of the insane are not resorted to until a reasonable period of observation has elapsed, and if the patient recovers quickly as so many of them do, they need not be resorted to at all. In this latter event, the patient and his friends have the satisfaction of knowing that he has not been sent to any but a military hospital and has not been officially declared as insane.

By relieving cantonment and other base hospitals of mental cases in this manner, the congestion of the general medical services has been lessened and a very much higher standard of care, with proportionate increase in speed of recovery, has been obtained. There has also been effected an economy of personnel,





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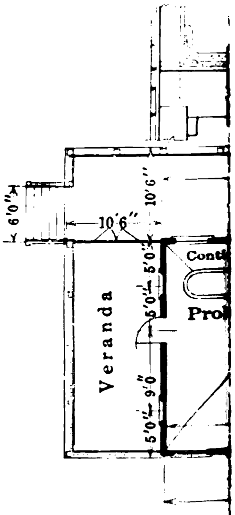
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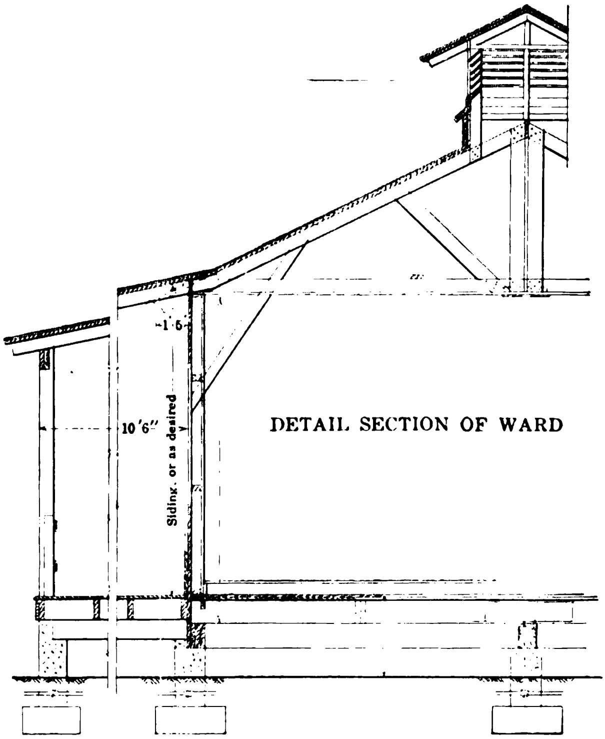
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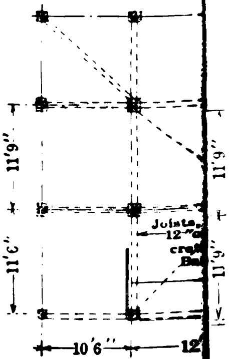
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NEURO-PSYCHIATRIC WARD

BASE HOSPITAL

UNITED STATES ARMY

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for even if it had been possible to supply base hospitals generally with sufficient number of psychiatrists to treat mental cases, it would have been extravagant in the extreme. With the speedy evacuation of all cases presenting mental symptoms, it is now possible for the nervous and mental work in a cantonment base hospital to be performed by one energetic and competent medical officer. As things have turned out this arrangement was imperative, for the need of neuro-psychiatrists at other points in the medical service does not permit, with the present number of these officers available, more than one at a cantonment base hospital.

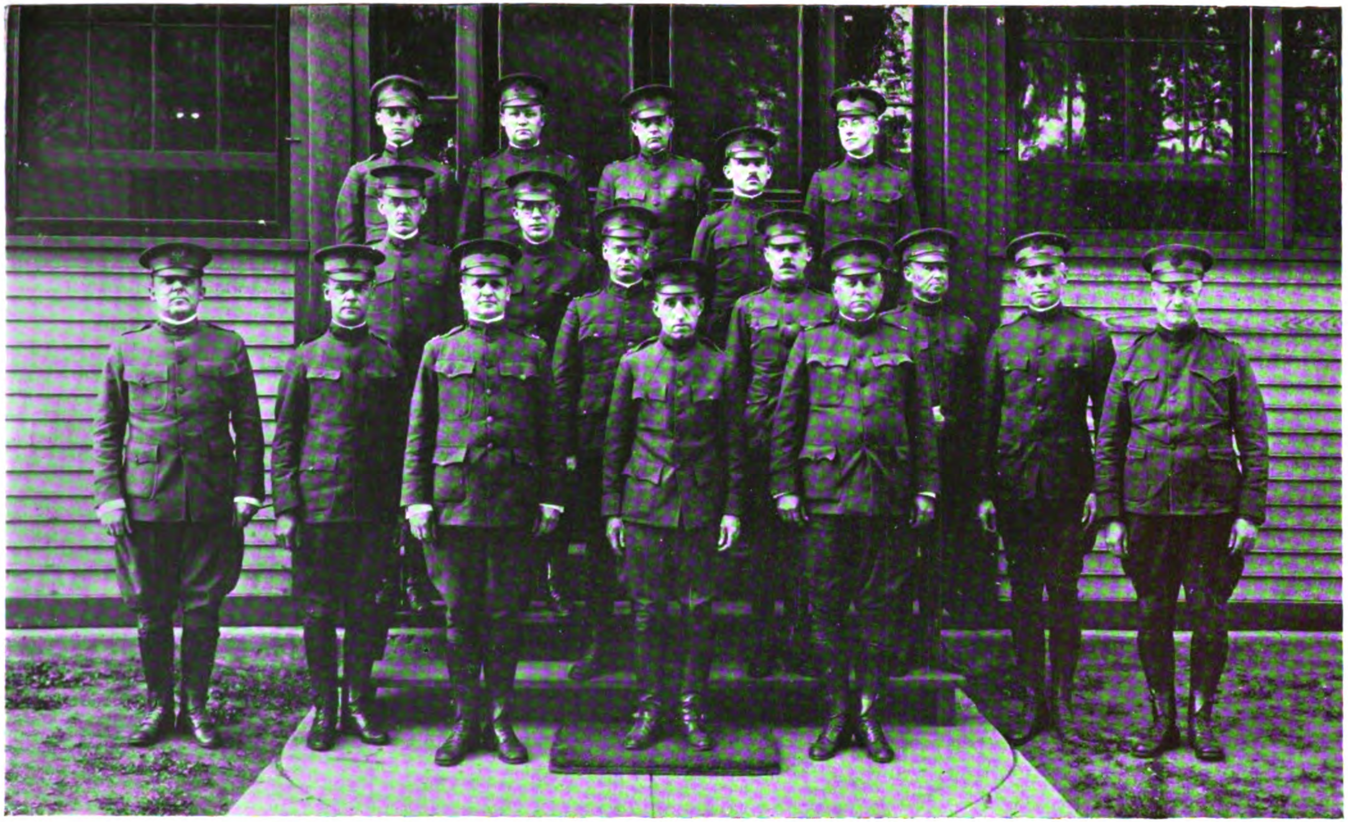
The efficiency of these centers has been gratifying. Extensive arrangements are being made for occupation, especially gardening. The recovery rate is high and the course of illness brief. For example, the average stay in hospital at Fort Porter is six weeks, at the end of which time the patients are cured or returned to their friends. Few cases have been transferred to permanent custodial institutions. The practical result is that this hospital, with a capacity of 150 beds can provide for 1,200 patients a year.

3. CARE AND TREATMENT IN CIVIL INSTITUTIONS

At the beginning of the mobilization, the Surgeon General wrote to the authorities in the different states, asking them if they would co-operate in relieving the Federal Government of the care and responsibility of recruits, in whom insanity existed prior to enlistment, or in whom it was not an incident to service. It was evident that cases of this character should not be a charge on the Federal Government. Most of the states thus communicated with responded with splendid and patriotic spirit. It gives me great pleasure to express for the Surgeon General to the state authorities who co-operated in this way, his great appreciation of their help. The arrangement in general is, with certain variations depending upon different methods of handling insane in the different states, that the military authorities would send patients of the above class to a point designated by the state authorities, and would then release the patient to the state authorities. This method has been of great assistance to the Medical Department of the Army, and, as will be shown later, has not put an excessive burden on the states. It has worked most satisfactorily when there was a central board with which all Commanders could communicate, and which could in turn at once indicate the special institution to which the recruit in question should be sent. In certain states not provided with committing officers the Surgeon General's Office has met the moderate fee which has been asked by physicians who executed the commitment papers.

For the use of insane officers, an offer by Bloomingdale Hospital, White Plains, New York, of fifty beds, has recently been accepted by the Surgeon General. The proximity of this hospital to the port of debarkation will make these beds particularly useful for expeditionary cases. The beds are administered as of General Hospital No. 1, which is located only a few miles distant from White Plains. Thus the patients will remain under military control, although actually cared for by the personnel of Bloomingdale.

St. Elizabeths Hospital, under the Department of the Interior formerly known as the Government Hospital for the Insane, at Washington, D. C., receives the insane from the residents of the District of Columbia and the insane from the military and naval establishments. Anyone may be sent to St. Elizabeths Hospital who is a member of the military establishment. An enlisted man, for example, who becomes insane from any cause may be ordered to St. Elizabeths for care and treatment. The hospital is constantly receiving patients, for whose cases the question of "line of duty" has not been considered, they having been sent with a request for an expression of opinion as to whether the cause is or is not "in line of duty." The Superintendent expresses himself when the facts warrant and whatever action has been taken by the War Department has never been considered to affect in any way the continuation of the care of the patient at the hospital. The question of "line of duty," however, becomes vital after the patient has been discharged from the military establishment. Then the benefits of the hospital are only open to him, provided his disability can be traced to service conditions. In other words, the whole thing may be summed up in a very few words by saying that all of the members of the military establishment are admissible to St. Elizabeths for care and treatment. After their discharge, however, they may only be admitted when their mental disability can be traced to causes which arose during and were produced by the service. This latter even applies to people who have been discharged from the service and who may become insane within a period of three years. If the insanity is traceable to the service they are entitled to the benefits of the



U. S. ARMY GENERAL HOSPITAL NO. 4, FORT PORTER, BUFFALO, N. Y. COLONEL WOODSON AND STAFF

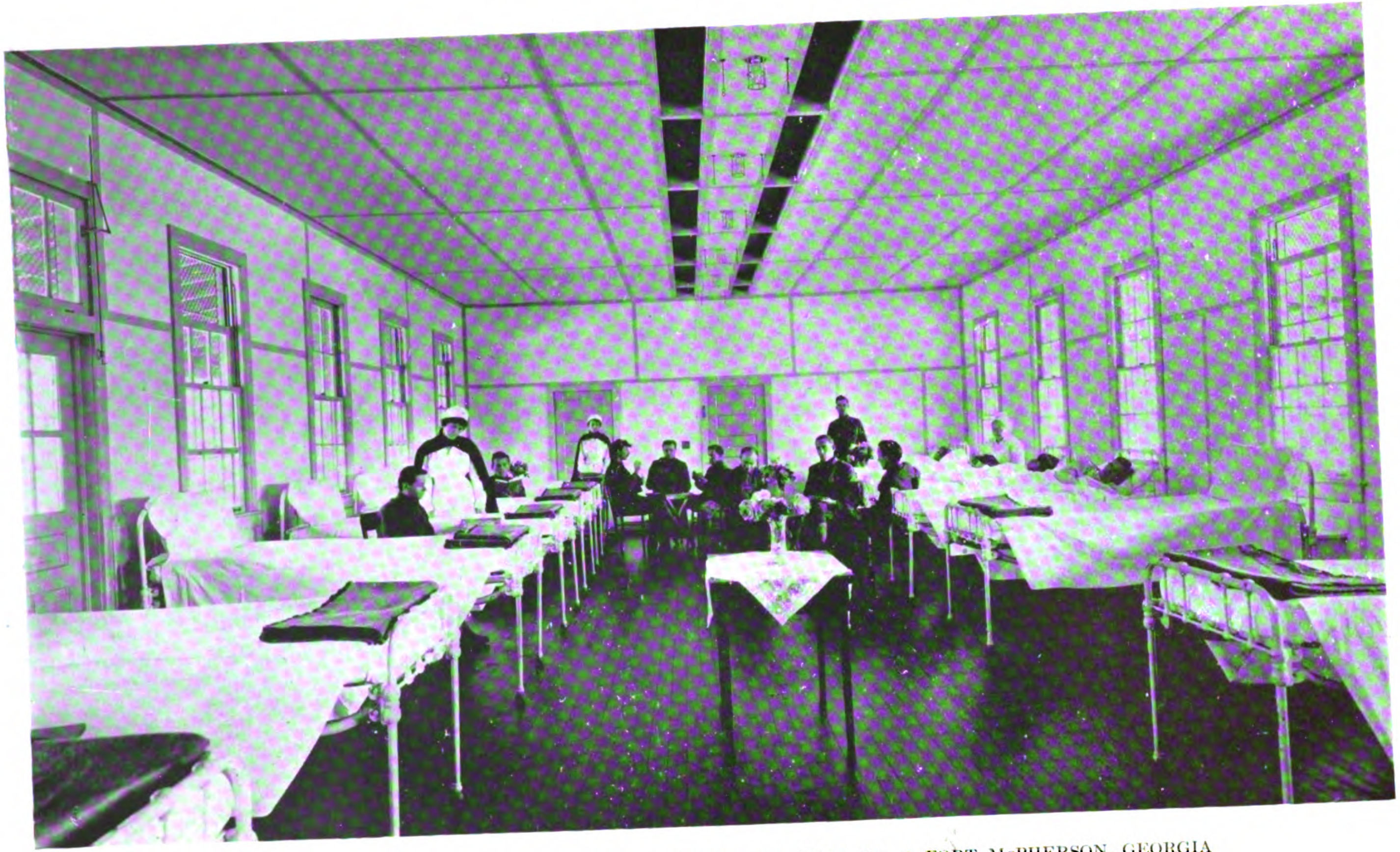
From left to right (on ground): 1st Lieut. J. H. Baker, ret.; Capt. Homer E. Safford, M. R. C.; Capt. A. E. Brownrigg, M. R. C.; Lieut. Col. Thomas D. Woodson, M. C., N. A.; Capt. Paul Compton, San. Corps, N. A.; 1st Lieut. O. E. Coleman, M. R. C.; Capt. J. A. Heatly, M. R. C.

(On first step): Capt. S. L. Goodrich, M. R. C.; 2d Lieut. E. F. Held, Q. M. C., N. A.; Capt. W. T. Patterson, M. R. C.

(On second step): Capt. J. G. Stowe, M. R. C.; 1st Lieut. P. J. Quinn, Chaplain, N. A.

(Rear row): 1st Lieut. L. O. Murphy, D. R. C.; Capt. L. R. Bice, San. Corps, N. A.; Capt. C. H. Mackey, M. R. C.; 1st Lieut. H. E. Cooper, M. R. C.; 1st Lieut. B. F. Hauenstein, M. R. C.

PROFESSIONAL STAFF, PHYSICIANS, NURSES, ATTENDANTS, NEURO-PSYCHIATRIC WARDS, U. S. ARMY HOSPITAL NO. 6,
FORT McPHERSON, GEORGIA



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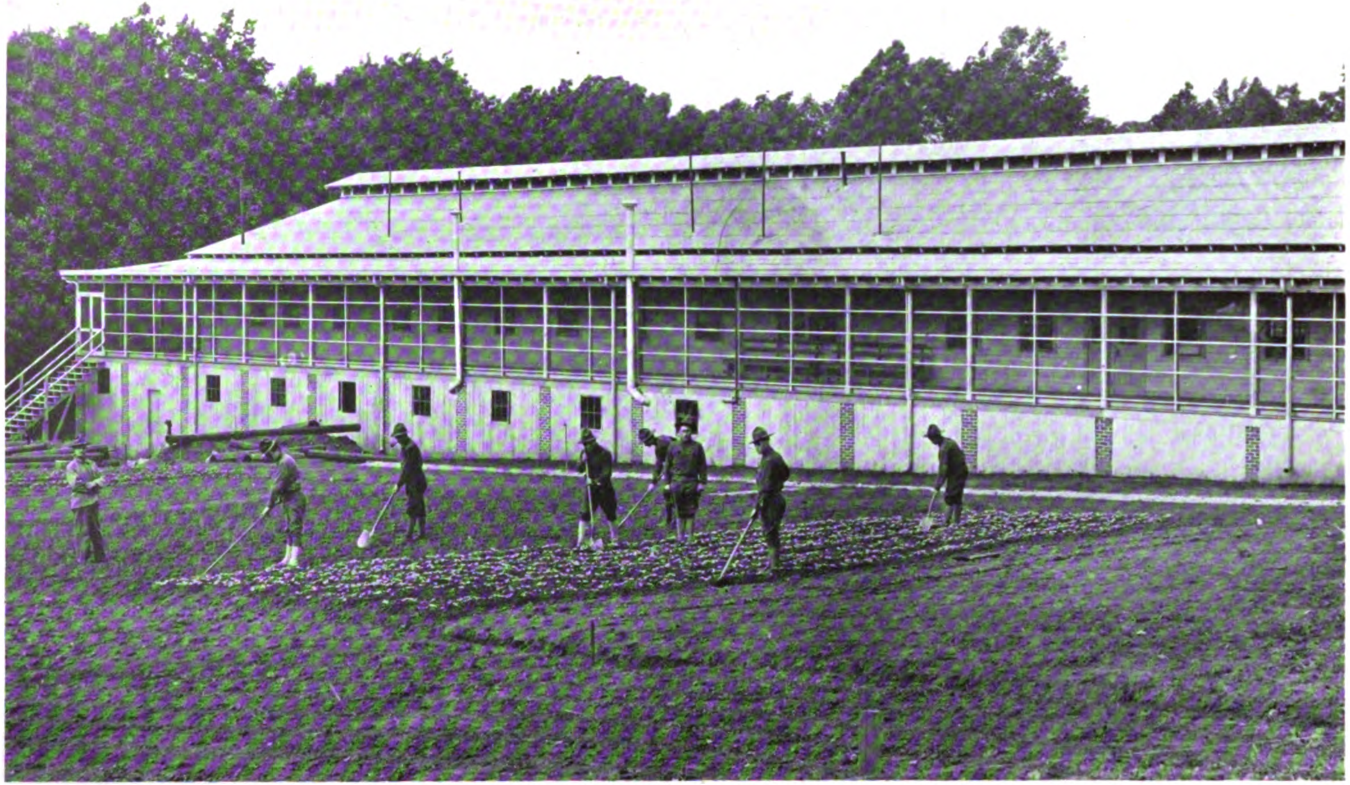
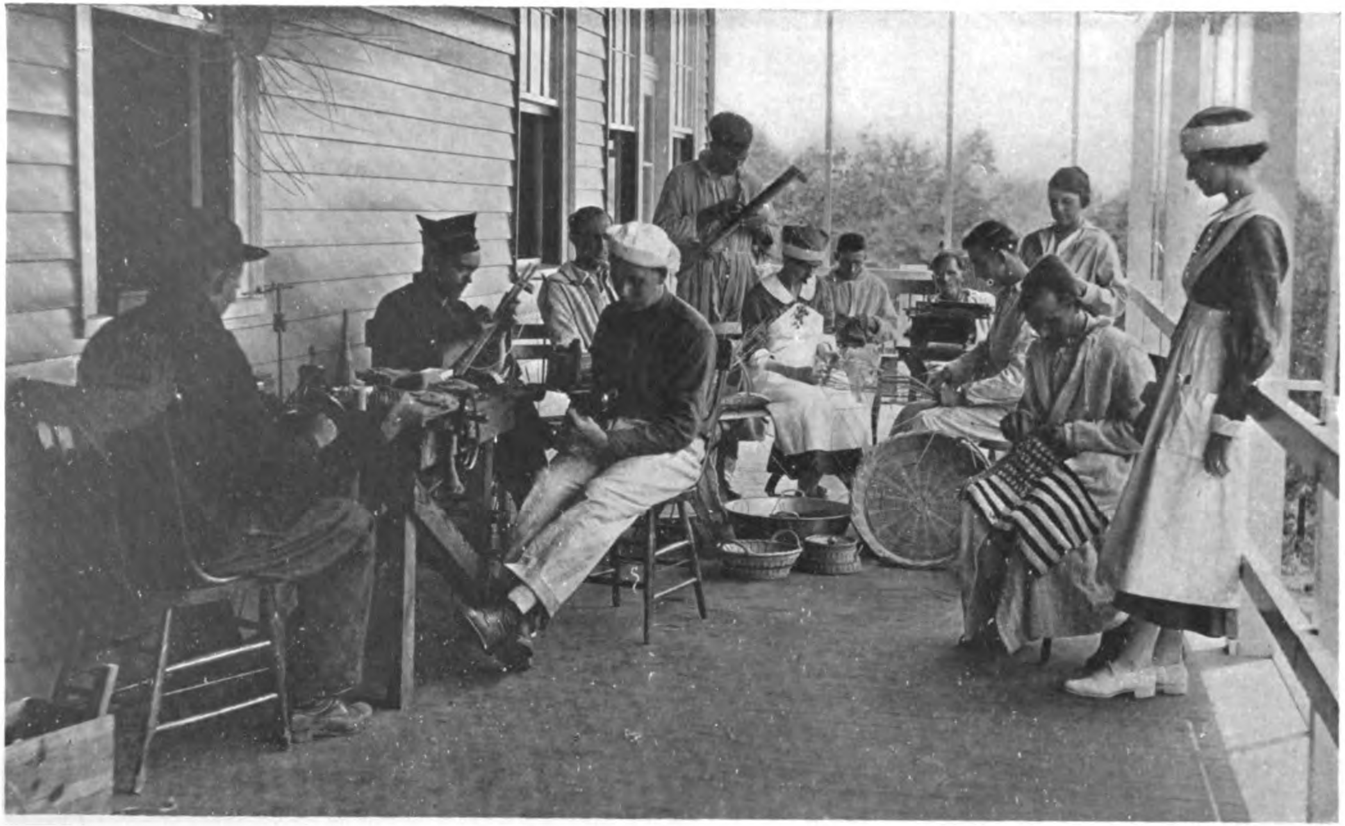


NEURO-PSYCHIATRIC WARD AND OCCUPATIONAL CLASS IN WAR GARDENING, U. S. ARMY GENERAL HOSPITAL NO. 6, FORT McPHERSON, GEORGIA

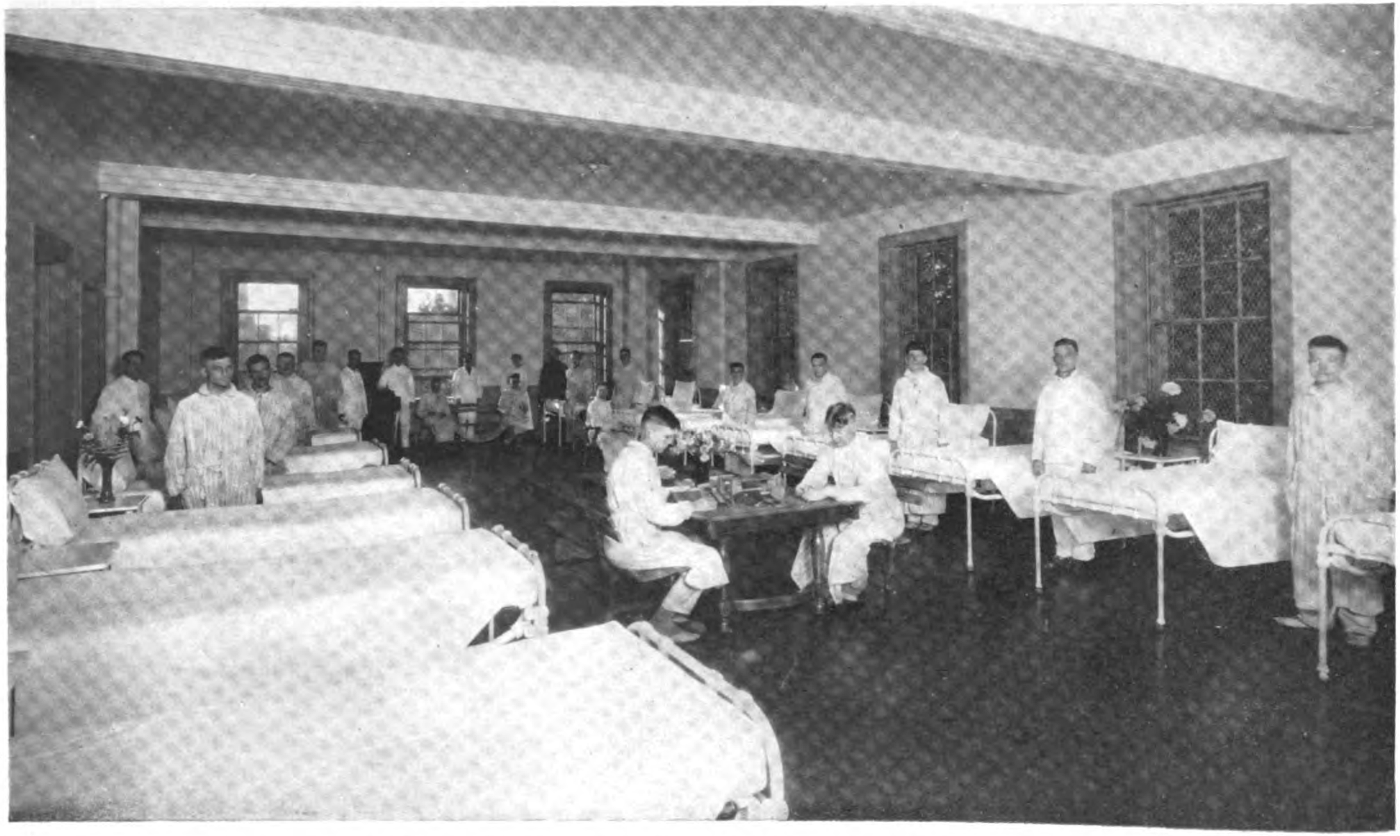
A NEURO-PSYCHIATRIC WARD, WALTER REED GENERAL HOSPITAL, WASHINGTON, D. C.



BASKET MAKING AND WEAVING, NEURO-PSYCHIATRIC SERVICE, WALTER REED GENERAL HOSPITAL, WASHINGTON, D. C.

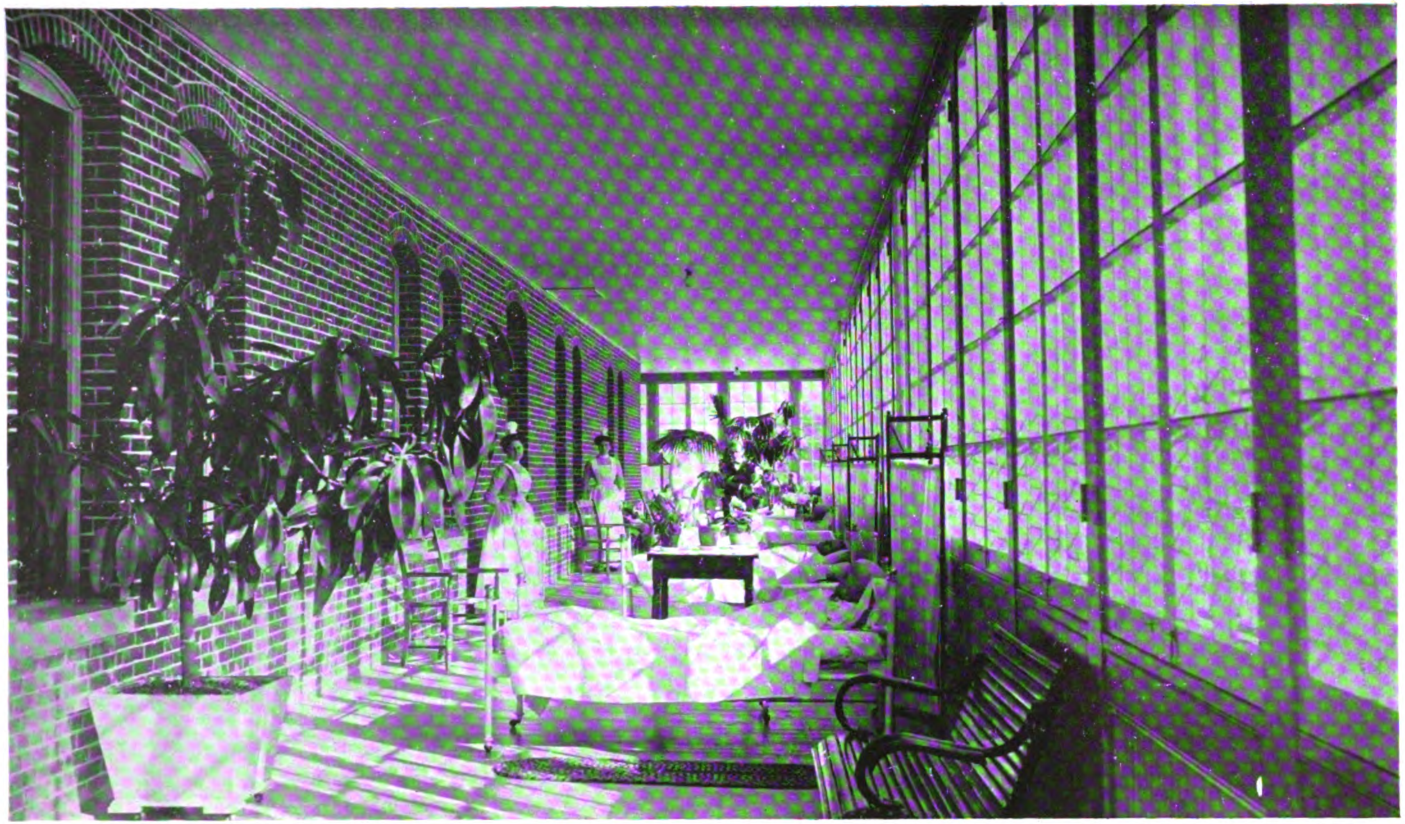
GARDENING, NEURO-PSYCHIATRIC SERVICE, WALTER REED GENERAL HOSPITAL, WASHINGTON, D. C.

NURSES (ARMY NURSE CORPS AND ENLISTED MEN, MEDICAL DEPARTMENT), U. S. ARMY GENERAL HOSPITAL NO. 4, FORT PORTER,
BUFFALO, N. Y., IN FRONT OF NEURO-PSYCHIATRIC WARDS

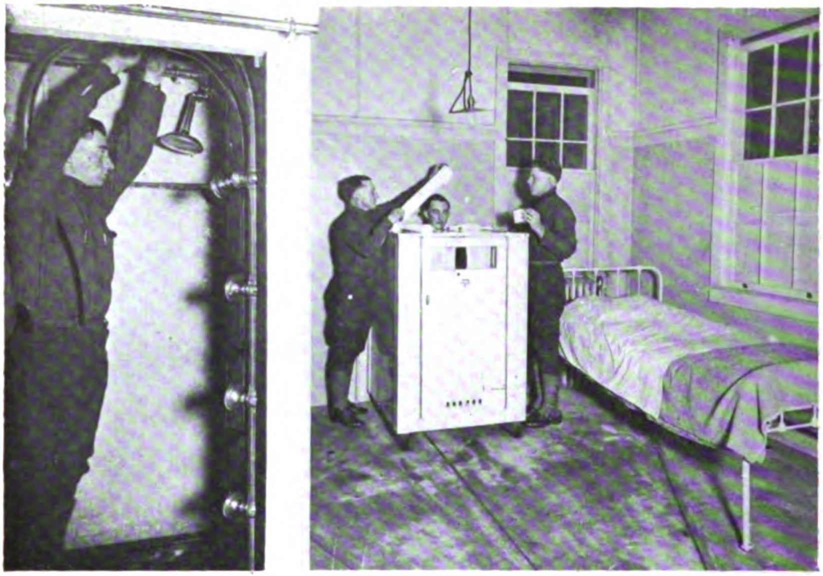


PSYCHIATRIC WARD, U. S. ARMY GENERAL HOSPITAL NO. 4, FORT PORTER, BUFFALO, N. Y.

ST. ELIZABETHS HOSPITAL, WASHINGTON, D. C.

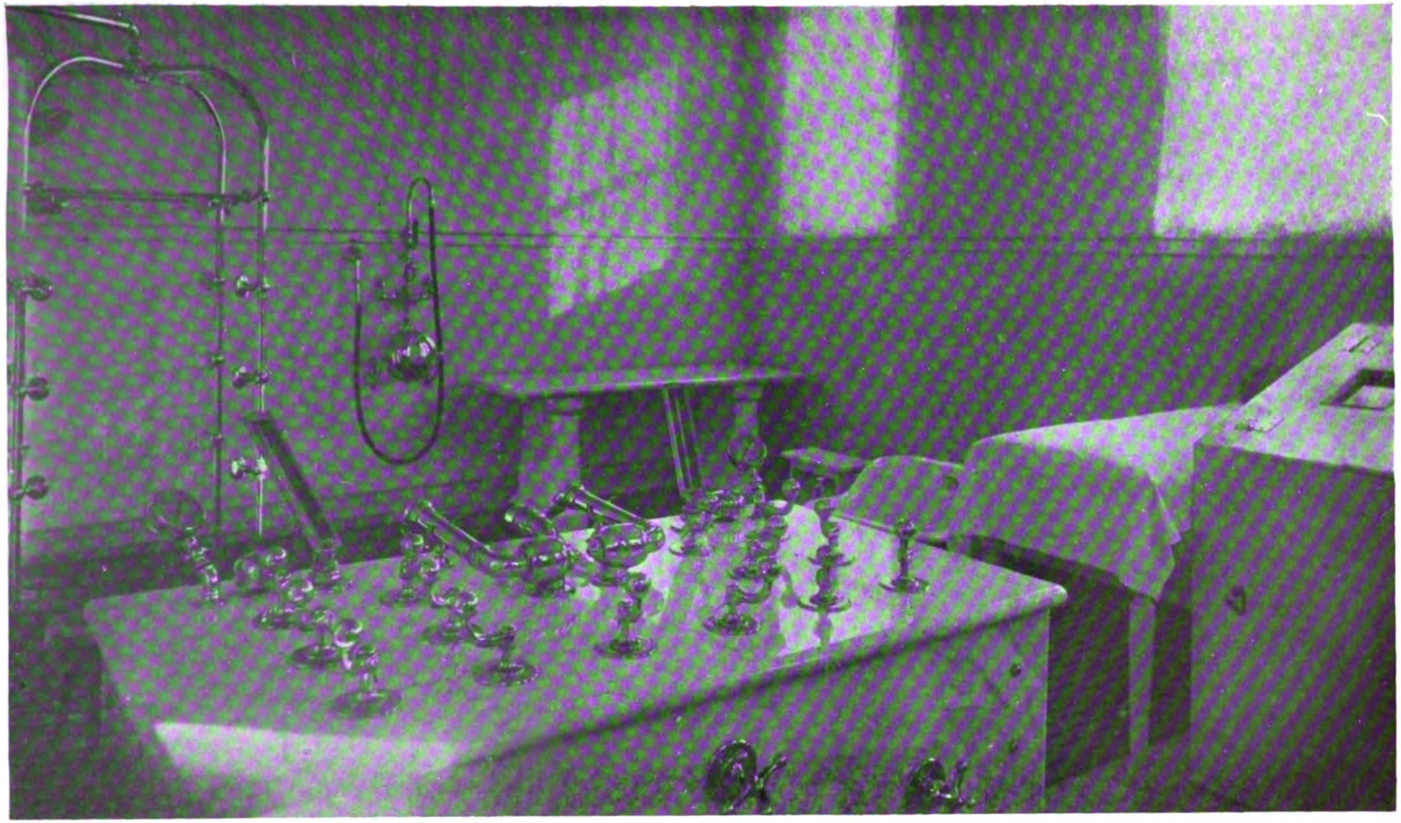


SLEEPING PORCH, ST. ELIZABETHS HOSPITAL, WASHINGTON, D. C.

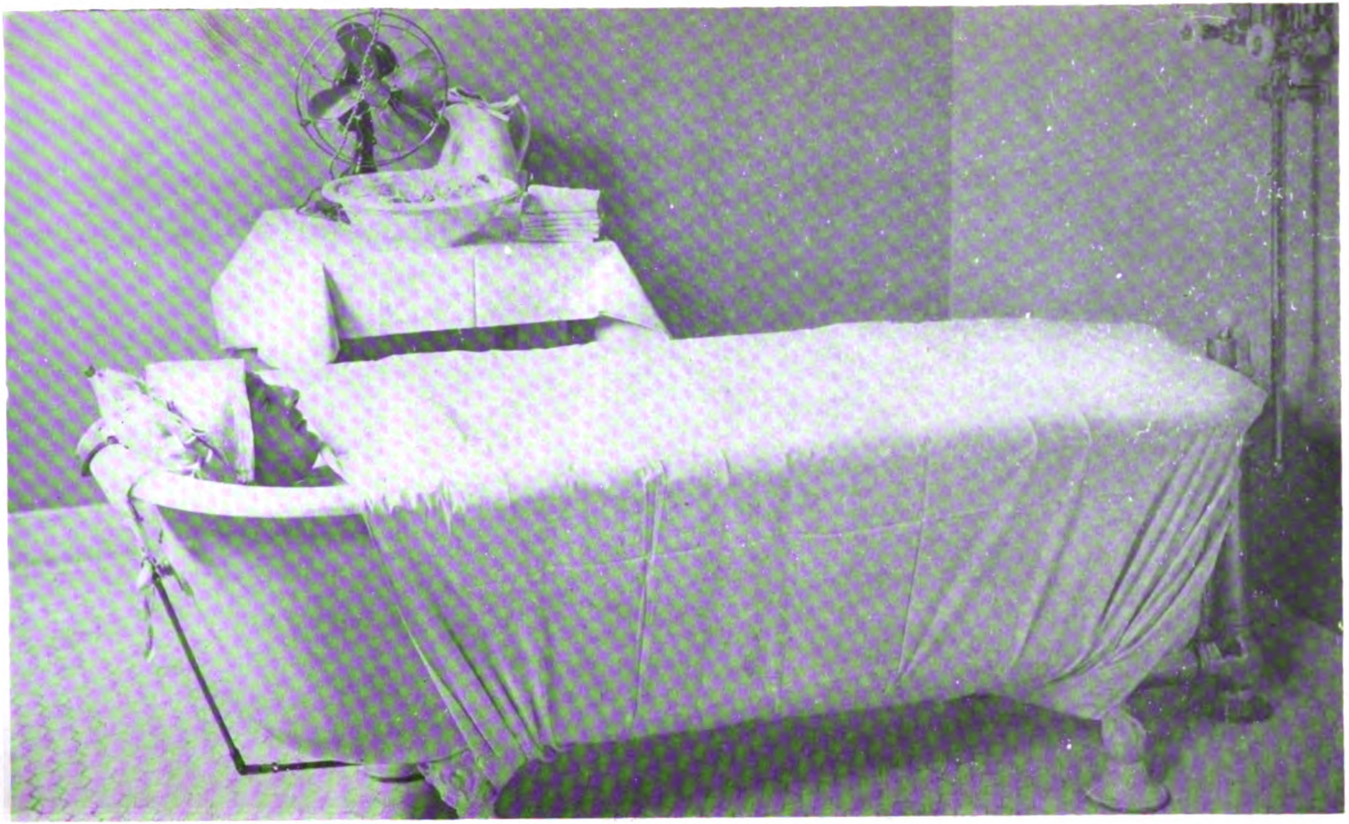


PHYSIO-THERAPEUTIC EQUIPMENT, NEURO-PSYCHIATRIC WARDS, U. S. ARMY GENERAL HOSPITAL NO. 6, FORT McPHERSON, GEORGIA

ELECTRICAL EQUIPMENT. NEURO-PSYCHIATRIC WARDS, U. S. ARMY GENERAL HOSPITAL NO. 6, FORT McPHERSON, GEORGIA



TYPE OF HYDROTHERAPEUTIC EQUIPMENT, NEURO-PSYCHIATRIC WARDS, U. S. ARMY GENERAL HOSPITALS, MENDOCINO STATE HOSPITAL, TALMAGE, CALIFORNIA



TYPE OF HYDROTHERAPEUTIC EQUIPMENT (CONTINUOUS BATH) INSTALLED IN NEURO PSYCHIATRIC WARDS hospital, otherwise not. The definitions of the various classes admissible to the hospital may be found in the Revised Statutes, Section 4843.

Until the present great increase in the size of the Army, St. Elizabeths had always been able to meet the requirements put upon it, but it could not be expected to do so with a larger Army. So the Superintendent, Dr. William A. White, in the summer of 1917, increased his budget for the following year to meet the increased number of patients expected, and also to provide for additional temporary buildings which are now in course of construction. But in addition to that he did a very wise thing. He secured Congressional action which confers on the Secretary of War for the present emergency, the authority to designate an undetermined number of civil hospitals, to be entitled to receive patients of every class exactly as St. Elizabeths now receives them. In other words, whenever it becomes necessary it will be possible to create arrangements with civil hospitals, so that they become, practically, temporarily branches of St. Elizabeths. The purpose behind the arrangement was not only to prevent St. Elizabeths from becoming suddenly full, but also to do away with the necessity of transporting to Washington patients from all over this great country. The previous arrangement, that was satisfactory for a small Army, would be unwieldy for a large Army. So far, the only hospital which it has been found necessary to have designated by the Secretary of War as on the St. Elizabeth status is the Mendocino State Hospital, Talmage, California.

4. EVACUATION: ARMY REGULATIONS

Prior to the present war all discharges from the Army by reason of insanity were made solely upon the order of the Secretary of War. This meant that all the papers in the cases of this kind were forwarded by local commanders to Washington, having first passed through Department Headquarters. This method implied delay before an insane man could be separated from the service, or be released to the custody of his friends, or sent to St. Elizabeths Hospital for treatment. One of the first things which was done to insure a great expedition in these matters in the new Army was the issuance of a general order which extended the authority of discharge to division and department commanders. This decentralization of authority was embodied in the changes in Army Regulations (C. A. R. No. 64, Amending Art. XLV,

¶ 464–70) which changes effected other improvements in the care and disposition of the insane.

Whenever military necessity permits, it is distinctly to the advantage of the Government to have a period of probationary enlistments of a few weeks. During that period many defects come to light which may have been passed over at the first hurried examination. During such a period, recruits unfitted for military service can be returned much more easily to civil life. Until they have taken the oath, the Government is less obligated to care for them than afterwards. For the insane of this class the following provisions now exist.

Applicants for enlistment and drafted men who are found to be insane after arrival at depot, post or camp, and before the completion of their enlistment by oath, muster in or otherwise, are disposed of as follows:

(1) Those whose liberation is unattended by danger to themselves or others, are rejected and disposed of under regulations governing disposal of other rejected recruits. In other words, cases of this class are disposed of in the same manner as are purely physical disabilities.

(2) Those whose insanity is of a type that would probably make their liberation a source of danger to themselves or to others are delivered to the civil authorities authorized by law to apply for commitment, of the place where they applied for enlistment or whence they were drafted.

This latter provision requires, if it is to be carried out in the sense intended, a close co-operation on the part of the civil authorities. It clearly points out the necessity of every state's having a central administrative point which can either receive emergency cases of insanity, residents of the state, or nominate the hospital to which such patients may be sent directly.

LINE OF DUTY

For the purpose of defining the Government's liability, the War Department must attempt to distinguish between disabilities which are acquired in the service and those which are not. Questions affecting care and treatment as well as pensions, are involved. In mental cases the question is particularly difficult to decide, but has become somewhat more concrete through recent orders; General Order No. 47, II, May 11, 1918, 710 A. G. O., provides that "any soldier who shall have been accepted on his first physical examination after arrival at a military station as fit for service, shall be considered to have contracted any subsequent determined physical disability in "line of duty" unless such disability can be shown to be the result of his own carelessness, misconduct or vicious habits, or unless the history of the case shows unmistakably that the disability existed prior to entrance into the service. The same ruling applies to the cases of officers who have been passed as fit for service on physical examination upon entrance into the service." This order, in which the term physical disability includes mental disabilities, admits that insanity may arise in line of duty unless the history shows its prior existence. As in the Manual of Instructions for Medical Advisory Boards, Form 64, P. M. G., it is provided that a previous mental disease should exempt from military service when it was severe enough to necessitate hospital treatment; it would seem that mental disease might be regarded as not having existed previously unless there was a record of hospital treatment for that cause. It is probable therefore, that disability boards will find more cases of insanity as having arisen in "line of duty" than they have in the past.

Before being recognized as insane by the military authorities, the patient must have passed before a board of at least two medical officers, one of whom shall, whenever practical, be a specialist in nervous and mental diseases. The examination shall preferably be made in hospital and in the special ward for nervous and mental diseases, if there be one; and the board will not make its report until the person being examined shall have been observed for a reasonable length of time. The report gives the diagnosis, a detailed account of the medical history of the case, and a statement as to whether the disability was or was not incurred in "line of duty"; also a statement as to whether the patient, if discharged from the service, can be released from control without danger to himself or others, and the board's recommendation for or against the patient's transfer for the treatment to an institution. If the insanity is reported as "in line of duty" and the board recommends treatment in a hospital of the class of St. Elizabeths, the patient is transferred to the institution on the order of a division or a department commander, or of the Adjutant General of the Army. "Non-line-of-duty" cases are handled in the same way, except that, they are not eligible after discharge to be cared for at the expense of the United States. But the new regulations provide provisionally for those cases in which the question of "line of duty" is in doubt or cannot be immediately decided, or in which care by home state or relatives is not immediately available. Patients will not be turned loose on the streets, in other words.

RATIO OF INSANITY TO TROOP STRENGTH

While not insisting on any rigid deductions from our still incomplete experience, certain facts stand out as significant even if not finally established. One of these is that the ratio of insanity to troop strength is much less than has been anticipated and that the elimination at the source, by means of the neuro-psychiatric examination, has been largely responsible for this.

In preparing for the insane of the new Army it was difficult to obtain figures as to numbers upon which definite estimates could be based. Those compiled previously to this war did not reveal what efforts, if any, were made to eliminate the insane at the source, nor did they state whether or not the cases required custodial care. It was known that a modern army, whether in England, Germany or the United States, would produce in one year, three insane men per thousand troops during peace, and that this number would be doubled in war, particularly in expeditionary campaigns. But it seems certain in all these statistics the term "insanity" was employed to include all the mental cases mentioned as constituting the 83.7 % of the present statistics, without information as to the effect of the mental condition on the individual's behavior or whether or not he required custodial care or could be released from control without danger to himself or to others.

Certain information concerning the ratio of hospital cases of insanity to troop strength were available from the statistics of St. Elizabeths, although it must be remembered that these by no means represent the total cases embraced under the term "insanity," as many of the acute psychoses, so common in the military services, recover in a few weeks, and do not reach St. Elizabeths. Army admissions to St. Elizabeths during the years 1914–1917 are as follows:

1914	77
1915	105
1916	179
1917	275

It was believed that the excitement and unexpectedness incidental to the preparation of a large Army would bring about a proportionate increase in that number. This belief has proved not only to be incorrect, but the ratio of insanity to troop strength has shown a decline.

In the first four months of 1917, St. Elizabeths' admissions from an Army of approximately 136,000, were 58. In the first four months of 1918, with an Army of approximately 1,000,000, they were 92. In other words, admissions to St. Elizabeths had not doubled although the Army had become eight times as large. The total number of admissions from October, 1917, when the mobilization began, to May 1, 1918, is 177. Up to the same date, 300 cases are reported as having been received back by institutions of the different states, making a total of 477 cases of insanity requiring custodial care, produced in eight months during the mobilization of an Army considerably over 1,000,000 men, instead of the 2000—3000 that had been expected. In view of the close association between delinquency and mental disease and defect, it is pertinent to note also that the military delinquents are much fewer than had been provided for.

MILITARY SERVICE AND INSANITY

This diminished percentage of insanity in any Army systematically examined with the view of eliminating those who might become insane, seems to contribute something to the answer of a question of military psychiatry which has never been satisfactorily answered. The question is this: Does Army life make men insane? The question is especially important in a warfare which involves the whole nation, as bearing upon the economic value of psychiatric examinations. As far as epilepsy and mental deficiency are concerned, the present statistics do not throw much light. While camp conditions might easily, and as a matter of fact often do, give rise to nervous episodes in the mentally deficient, they have nothing to do with the underlying cause. The same may be said of epilepsy. The frequency of attacks in epileptics may be increased after entering the Army, but figures so far obtained do not justify the assumption that a potential epileptic under peace conditions is converted into an actual one by Army life. But the matter is quite different with the psychoneuroses, constitutional psychopathic states and dementia praecox. It seems that even in the training camps any of these conditions may become active and conspicuous through the requirements of military service when they had not manifested themselves to a degree to be incapacitating in civil life. It is not believed that this conversion of a potential psychosis into an actual one in the camps is a result of hardship or physical causes. It is believed rather to be a psychological result from disharmony with new and rigid conditions which the neurotic, who is so intensely individualistic, finds it impossible to adapt himself to and so breaks down. This explanation holds true for those who have volunteered quite as much as for those who have been drafted.

As far as the expeditionary forces are concerned, the time has not yet come to explain the method of production of psychoses. Most of the wounded so far returned had departed for France before the neuro-psychiatric examinations had been established. Among them there is a percentage of nervous and mental disease of twenty-five, a percentage that seems destined to decrease as the figures more and more concern the examined Army.

Our experience indicates that a pronounced psychopathic constitution and military service are antagonistic. It is believed on the other hand that psychoneurotics who might render excellent service in their civil capacity, become incapacitated by the change in their habits of living however patriotically they may have sought it. It is also believed that the Army fares better without them.

Instances can doubtless be brought forward to prove the contrary. Great generals may be cited as epileptics, great leaders who were fanatical to the point of insanity, and others who with unmistakable symptoms of psychoses were nevertheless famous strategists; but these exceptions are rare and do not affect the rule, now well established, that those expected to work effectively and harmoniously under the orders of others must be of sound nervous system.

A SURVEY OF WAR NEURO-PSYCHIATRY*

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IT has been my privilege to have a wide vista of neuro-psychiatric work, as prior to my present position I was in charge of wards in the Neurological Section of the Royal Victoria Hospital, Netley, where a large percentage of the cases with psycho-neurotic disorders were admitted. The British medical world was ill prepared for the treatment of these patients, for previously little scientific interest was taken in such sufferers. The average neurologist after a careful examination, and finding no sign of organic change would label the case "functional," and apart from some banal advice, the use of simple physical measures such as electricity, massage and hydrotheraphy, with the probable administration of that presumed panacea for all nerve troubles, "bromide," nothing further would be done to endeavour to search for the real pathological basis. As Freud[1] well puts it—"The doctor acts quite differently towards hystericals than towards patients suffering from organic disease. He will not bring the same interest to the former as to the latter, since their suffering is much less serious, and yet seems to set up the claim to be valued just as seriously. But there is another motive in this action. . . . Before the details of hysterical symptoms, all his knowledge, his anatomical, physiological and pathological education, desert him. He cannot understand hysteria. He is in the same position before it as a layman. And that is not agreeable to anyone who is in the habit of setting such a high valuation upon his knowledge. Hystericals, accordingly, tend to lose his sympathy; he considers them persons who overstep the laws of his science, as the orthodox regard heretics; he ascribes to them all possible evils, blames them for exaggeration and intentional deceit, 'simulation,' and he punishes them by withdrawing his interest."

This unsympathetic attitude was so extremely prevalent, that the neurotic soldier was upon no "bed of roses," unless by chance he happened to get into the hands of a medical officer whose outlook was widely different. It was no wonder then that the question of high explosives as a possible factor to explain psychoneurotic symptoms should have been jumped at by the medical profession with the result that every nervous disturbance without visible signs of injury was labelled shell shock, and learned lectures and treatises were given forth showing how the concussion, even at a distance, and the formation of noxious gases in the vicinity would account for all that was seen in these cases. The followers of this theory were many, and the treatment which naturally would be based upon it, known as the so-called "common sense treatment," which involved only rest and quiet surroundings, resulted in the great majority of the sufferers becoming chronic invalids and being finally discharged from the service with pensions. Major A. F. Hurst (Proceedings, Royal Society of Medicine, Section of Neurology and Psychiatry, April, 1918) states from his own experience, "There are hundreds of men suffering from war neuroses scattered through the central and convalescent hospitals of England, where they spend many weary months without adequate treatment. At the end they are often invalided from the service still suffering from their original symptoms, like two men admitted under Captain Symns, who were working on a farm the day after their arrival at Netley, *although only ten days earlier they had been awarded 100 per cent pension for total incapacity due to hysterical paraplegia.*"*

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* Publication approved by British War Office.

Our medical education and organization are mostly to blame for the limited number of physicians capable of undertaking neuropsychiatric work. Our neurologists have no psychiatric or psychological training. The mind is studied only in the light of neuronic functioning. The psychiatrist on the other hand usually has no neurological training and the British School of Mental Medicine is so deeply imbued with materialism that the majority of its members earnestly proceed with the search for some mythical toxins as the one and only causative factor of mental abnormality, with the result that the human factor, the individual conflict with the environment and the social and biological standpoints are quite lost sight of. The clinical war experiences, nevertheless, have forced the study of modern psychopathology to the fore. Psychopathology in all its various branches has been taken up, and now the most conservative physicians have been heard to state that perhaps there is "something in it."

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* The italics are mine.

Suggestion, hypnotism, persuasion, psychotherapeutic conversations, psycho-anaylsis, all have their special advocates, and one special form of treatment is commonly extolled to the exclusion of others. Babinski's pithiatism has seemed readily acceptable to many neurologists, and perhaps it is hardly to be wondered at, for though his view at the time did mark an onward step in the pathology of hysteria, its comparative simplicity is attractive to those who have no scientific desire to seek a more profound pathology. Why the hysteric is so suggestible does not seem to worry the follower of Babinski. That he is so is sufficient, and that is why he so easily attains his symptoms. That hypersuggestibility is found elsewhere besides in hysteria is not taken into account.

Whether the Freudian view of the origin of the neuroses applies equally to the war neuroses is stated by Ernest Jones[2] to be "sub judice" though there is every reason to believe that the psychological mechanisms involved will be to some extent modified by the special circumstances and environment of war.

A good deal of literature has been devoted to neurotic war diseases, but it has mainly dealt with the descriptive side and if the question of etiology or pathology has been spoken of, it has been treated more or less in a superficial way.

Mott[3] lays stress largely upon the physical factors of concussion, the inhalation of noxious gases, and in no way differentiates the different types of nervous disturbance met with, but roughly classifies them all under the heading of shell shock, which renders his statements so largely valueless.

Eder[4] in his small book is dogmatic in regarding the psychoneuroses of war as due to Freudian mechanisms, which he illustrates from his 100 cases; but to the average reader he would seem to take a good deal for granted and rather spoils himself by his extreme reliance on hypnotic suggestion alone by means of which he states he cured 91.5 per cent of his cases, and improved the other 8.5 per cent.

Myers[5] has made many interesting observations on cases he met with in France, but his studies were limited to certain types of disorder.

Hurst,[6] in common with so many other authors, speaks vaguely of the effect of fear and other emotions as causative factors, but throws no light on the essential pathology. He also is a supreme believer in Babinski's pithiatism and has no sympathy with modern psychopathological trends.

Farrar,[7] has given us much interesting matter and his discussion on the etiology of the war neuroses from the psychogenic standpoint is distinctly edifying and enlightening.

The French have added little to our knowledge of psychopathology, although excellent and careful clinical studies have been made. Babinski's well known views are put forth in a Military Medical Manual,[8] and ably seconded by Roussy and Lhermitte.[9] By far the most illuminating writing on the subject of the war neuroses is given us by MacCurdy[10] who traces the various symptoms "ab initio," points out the various mental conflicts that take place in the patient and the mechanisms involved in the production of the final clinical picture. He deals, however, almost entirely with conversion and anxiety hysteria, but devotes some small space to consideration of the relation between functional cardiac trouble and psychogenetic factors. It seems to me to be doubtful if he is correct in assuming that man's aggressive instincts are "sublimated" in active warfare and that the commencement of the neurosis is due to the failure of this sublimation whereby he becomes more individualistic and so feelings of personal harm become paramount. If by sublimation we infer the drafting off of instinctive energy into higher channels such as takes place in modern civilization in the form of competition in sport, business and position in life generally, it is a moot point whether or no the combative spirit and even love of destruction of the enemy is not a loss of that sublimation from the loss of inhibition which is now sanctioned by society and promoted by herd instinct. From this point of view the onset of the neurosis would mean a tendency to a return of the sublimation with a correlated weakening of the herd influence. Much depends on our exact meaning of the word "sublimation."

The point is an interesting one and I think merits further discussion. The last work to appear on this subject by the Resident Medical Officer of the National Hospital for the Paralysed and Epileptic, London,[11] deals almost entirely with the motor neurotic disorders and adds nothing to our pathological knowledge, but only illustrates the extreme efficacy of treatment by persuasion in these particular cases.

Time and space will permit me to give only a brief summary of my clinical experiences in the war neuroses. I would classify the cases as follows:

1. Neurasthenia
2. Hysterical manifestations
    a. Conversion Hysteria
    b. Anxiety Hysteria
    c. Amnesic Fugues
    d. Amnesias
3. Obsessional Neurosis
4. Convulsive Attacks
5. Stupors
6. Puerilism (Mental)

1. NEURASTHENIA

This term even at the present day among the majority of men is used in so loose a way that almost any nerve disorder short of insanity, that is not patently hysterical, is thus connoted. And yet modern psychopathologists have marked out a very definite syndrome as designative of this disease, and when other morbid symptoms present themselves it only leads to scientific and nosological confusion to bring this term into use. In the face of this we see hospitals organized for "neurasthenic" officers and soldiers, and Colonel Sir John Collie in a recent article in MENTAL HYGIENE[12], writing at length on this disorder as though it were the prevalent nervous disorder met with in the war, makes such statements as the following, "Most, if not all, of the cases of neurasthenia arising in the Army are the result of actual concussions (shell shock), or the conditions prevailing in modern warfare." "It is obvious that the origin of the *conglomerate collection of symptoms** which go to make up the content of neurasthenia is mental." Greater scientific accuracy is required than this, after the 40 years since it was described by Van Deusen. Ernest Jones states,[13] "The term should be restricted to its primary meaning of a fatigue neurosis, the cardinal symptoms of which are an inordinate sense of mental and physical fatigue, difficulty in concentration of attention and application to work, sense of pressure on the head, spinal irritation. Gastro-intestinal symptoms such as constipation and flatulent dyspepsia also occur but are more closely related than the other symptoms to complex psychogenic factors. Hypochondriacal symptoms, most often genito-urinary, form a common complication and are definitely psychogenic in origin. Even the syndrome is only to be regarded as true neurasthenia in contradistinction to neurastheniod, after it has been shown not to be secondarily produced by some other disease, i. e., as a toxic state as a sequel to influenza or typhoid."

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* The italics are mine.

In my experience with the war neuroses neurasthenia is decidedly rare and I only met with one or two cases that could properly be brought under this heading. Eder and Ernest Jones concur in this view and Hurst tells me he does not meet these cases in England though he did so when on duty in the Servian campaign. However we may look on the pathology of this disease, the fact remains that the above syndrome is uncommonly met with. That the exhaustive factors of warfare *per se* will produce neurasthenia is of course untenable for a moment, otherwise during the late events in France we should have had ample evidence of the fact. Whether Freud is correct or not in his ideas that neurasthenia is brought about by excessive masturbation or frequent pollutions, is beside the point. Undoubtedly the disease so frequently termed neurasthenia is really anxiety hysteria, which disorder is so ably discussed by MacCurdy in the article already referred to.

2. HYSTERICAL MANIFESTATIONS

The large bulk of the neurological disorders met with fall under this heading. Conversion hysteria is seen more amongst the men, while anxiety hysteria is more prevalent among the officers. Every possible variety of somatic disturbance, both sensory and motor may be met with in the former and in both forms physical and mental symptoms always co-exist, but it is the latter which require investigation and treatment. In this rapid survey it will serve no useful purpose to detail the manifold clinical pictures that may present themselves. Paraplegic states are very common following upon physical traumata, as are also disorders of gait and involuntary muscular movements. Speech disorders are frequent including mutism, aphonia and stammering. Hysterical deafness often is combined with mutism after shell shock, while functional blindness, diminished vision and blepharospasm are also met with. Monoplegia and local partial paralysis are more commonly met with as complications or sequelae of definite injuries and are seen more in the surgical wards.

For an insight into the various psychological mechanisms which may be involved in the production of the various somatic symptoms one cannot do better than refer to Eder's treatment of the subject in his work on "War Shock."[4] Sensory abnormalities are of course constantly found but usually in conjunction with motor ones.

In *anxiety hysteria* the most prominent symptoms are mental—a feeling of anxiety and dread without definite cause, sleeplessness often with terrifying dreams, headache, great exhaustion after trivial mental or physical effort, constituting the most prevalent type while special phobias may complicate the picture. The psychopathology of this disease is of great interest. As already stated it is much more commonly seen in officers whose responsibility is so much the greater and whose intelligence tends to prevent them from having conversion hysteria. MacCurdy, in his article already alluded to, discusses excellently the gradual development of symptoms through fear repression and mental conflict until some accidental trauma lights up the fully fledged anxiety state. Readers should refer to that, for no other writer has so clearly and so adequately thrown light upon its pathology. MacCurdy shows that the physical and emotional trauma of high explosives is only the last straw which sets aflame and brings to a head suddenly a neurotic state which has been more or less slowly incubating for some time, but I see no reason why, at times such a trauma should not of itself produce neuropathic symptoms in those who had much dynamic repressed material prior to war experience. One effect of the trauma will be to bring about a certain amount of loss of inhibition whereby failure of repression may easily come about. Any factor causing loss of conscious control may temporarily bring previously repressed complexes to the surface in some distorted way in a psychopathic constitution, and I have certainly met with such causes among the war neuroses where no mental conflicts of any moment could be traced immediately prior to the shock. Stanley Hall[14] in his genetic study of fear points out that the effects of shock are always more or less reversionary, that they strike the weak points and may erupt at any phyletic level. Thus shock and probably fear reactions and the diathesis of vulnerability to them may vary much with individuals and in general; to understand them we must not only know the personal history of the subject but something of the laws of heredity and the history of the race. This idea of shock bringing out prehistoric and sometimes even embryonic activities is one which is not sufficiently borne in mind in considering some of the mental reactions met with under war conditions and I therefore introduce it to the notice of workers in neuro-psychiatric war cases, as I believe that it is of value and should fill a niche in our mental pathology.

The phylogenetic aspect should be considered much more than it is, and I am inclined to believe that some of the stuporose states met with have a likely kinship to the cataplexy seen in animal life. It is doubtless often an endeavour to negate reality, but also may involve a self-preservative negation of movement. At any rate these ideas are suggestive. It should not be lost sight of nevertheless that in perpetuating signs and symptoms the internal secretions may secondarily play a part, and that adjuvant treatment directed to this point may be very helpful. Cannon's work,[15] on the relation of the emotions to the endocrine organs is highly stimulating.

Space precludes me from alluding to other hysterical manifestations met with, but, briefly, *amnesic fugues* are constantly seen in the front line and in all probability more than one such sufferer has been shot for desertion. Court martials on such cases are frequent and in most cases they are officially regarded as temporarily insane, not responsible, and sent home. The patient may or may not have been the victim of some physical or psychical shock. He wanders away a variable distance and when he comes to himself, or gives himself up, or is apprehended, he has a complete amnesia for the period of the fugue. On regaining his personal consciousness he commonly complains of headache, nothing more, though some slight obfuscation may exist for a few days. Quick recovery is the rule and by the time he reaches England there are no objective abnormal signs and no untoward symptoms except the special amnesia, which memory gap can usually be easily recovered by simple psychotherapeutic measures, such as simple association in a passive or hypnoid state or by hypnotic suggestion.

Amnesias of various types without any fugues are also frequently met with, and I am only referring here to those of a purely psychological type and not to those following a definite *concussio cerebri* though these may have some relation to some physical or psychical trauma. The amnesia may involve some limited period of time. It may involve the memory since enlistment, or it may be so retrograde as to involve the whole of life's experiences, so that the patient does not know anything of his previous history, not even his name. It is upon such a foundation as this that secondary personalities are formed. Some of these cases are difficult to cure but the majority yield to proper treatment with patience. The question as to the genuineness of these fugues has been often doubted more especially by those who having no knowledge of or interest in psychopathological medicine are always ready to see evidence of malingering in such conditions. Nevertheless all competent observers regard these fugues as a very definite pathological state akin to somnambulism. The wanderings of course are not purposeless any more than sleep walking is, and there is good reason for believing that a desire to leave the particular environment involved, which has been very likely conscious at one time and then repressed into the unconscious, is the basic factor. Superficial psychological investigation of such cases support such a theory. It is therefore often unconscious desertion. Consciously, desertion would not be entertained seriously as a mode of reaction to the conflicts that beset them, but in neuropathic individuals when factors produce some loss of conscious inhibition, the unconscious takes control and a fugue results. Many have shown similar tendencies in civil life. The soldier with a normal mental constitution is not likely to show this symptom. I may mention here, that malingering in any form is not commonly met with in the ranks, and if found the individual generally shows on careful examination evidence of some mental defect.

3. OBSESSIONAL NEUROSIS

No remarks are needed concerning this neurosis as they seem to differ in no way from the cases met with in civil life, have often no evident relationship with war experiences and are not frequently encountered.

4. CONVULSIVE ATTACKS

Much work remains to be done with regard to the pathology of convulsive states. We do not talk of epilepsy now so much as "the epilepsies." Of late years L. Pierce Clark has done excellent work showing that epilepsy has so largely a psychogenetic basis, and that by an understanding of its particular mental reactions the condition may be greatly alleviated, if not cured, although the tendency to be epileptic is likely to be of an hereditary nature. When in charge of the neurological wards, I had all the cases of convulsions admitted under my care and it soon became evident to me that the numerous patients sent in as epileptic were not so at all and these largely comprised those who had had no convulsive attacks prior to enlistment. It has in the past been more or less customary to lay down certain rules as to whether an attack was hysterical or epileptic and types were often met with which according to those rules puzzled the physician. I do not believe there is any hard and fast line to be drawn between the two diseases in this respect, and that all grades of attacks may be met with from typical emotional hysterical attack to the typical epileptic convulsion. Since we are gaining a glimmering into the psychic element in epilepsy, there seems no reason why a definite line can so be drawn. That the condition hitherto regarded as *petit mal* should really belong to the psychoneuroses is more and more forced upon us. Ernest Jones, in a highly stimulating article,[16] states that as a result of our advance in knowledge, the modern tendency has been to base the differential diagnosis in doubtful cases upon an investigation of the mental state of the patient during the free interval rather than upon the symptoms displayed in the fit itself. Hoche[17] has shown that one after another the various features that had been advanced as distinguishing an epileptic from a hystero-epileptic fit have been proved to be non-pathognomonic, until at present it is definitely known that every symptom of a *grand mal* fit, from fixed pupils to sphincter relaxation, may occur as well in functional affections as in idiopathic epilepsy, although of course the features referred to are more frequent in the latter condition. Heilbronner even goes so far as to refuse to diagnose epilepsy in the absence of the characteristic mental changes found in that condition apart from the fits. Binswanger[18] maintains that there is no sharp dividing line, as I have already conjectured, and that one state may pass over into the other. I dwell upon this point because I regard it as of great scientific importance, and in order that neuro-psychiatrists may be upon their guard and not hastily label these states, the differentiation of which is vital to treatment and the future of the patient. American medical officers who are in the position to study such cases from the war zone will have a chance here of making valuable observations and adding greatly to our knowledge in this department of psychopathology. It is easy to understand that complex adaptations required of the soldier, who is recruited more or less suddenly from civilian life, will tend to produce mental conflicts, the reaction to which in many may be some anomalous convulsive attack which requires special care and knowledge. It has been far too much the rule to jump to the conclusion at once that the man is an epileptic and discharge him from the army forthwith accompanied by a certain stigma which is so often undeserved. Pure epilepsy has in the majority of instances shown itself prior to enlistment.

In the careful and systematic recruiting examination that the American War authorities, I believe, have instituted these psychopathic trends will not be neglected, but taken into account, which will mean the saving of an enormous amount of mental sickness in time to come.

5. STUPORS

Not infrequently stuporous states are met with apart from organic lesion and not distinctive of any psychosis, though it may be difficult at first to differentiate them from dementia praecox. They evidently depend on mental dissociation. An inherent unconscious desire to shut off reality is probably often a basic psychological factor. In severe cases the patient is for a time entirely unconscious of his environment. He seems neither to see nor hear, no words are uttered and there is hardly any or no response to sensory stimulation. Food is automatically swallowed. The condition varies in severity and duration, and he usually gradually regains his normal state. The milder cases can be temporarily roused and their attention gained momentarily. Some may utter a few words connected with war experience demonstrating a dream-like state. Lepine[19] regards these cases as an annihilation of consciousness tired of struggling, the man becoming inert and subconsciousness carrying on. Defense mechanisms are not seen, and the condition may pass on into ordinary sleep. It is a sort of defense of the organism and might be regarded in a biological light. Hoche regards these states as representing one of the typical biological reactions of the organism, a reaction of escape from the environment, and says it is quite in harmony with this and with the growing conviction that the essential motive in the functional psychopathic states of shell shock is a desire to get out of the situation, that stupor seems to be relatively frequent in the war. The stuporous conditions described among the prison psychoses would have largely the same pathology.

6. MENTAL PUERILISM

This condition is somewhat uncommon but pregnant with interest. Two cases came under my observation. Both cases were just over 20 years of age and apart from general nervousness the main symptom they presented was that of childishness in speech and behaviour. They spoke in a childish way, giggled stupidly, and adopted the attitudes and mannerisms of a spoiled boy of about six years of age. They found pleasure in the most inane trivialities which their ward mates soon found out with the result that discipline often became difficult. One continually reminded us that he wanted his mother. Both patients were very neurotic and one was an only child. As regards the pathology of mental puerilism it seems from a study of the literature on the subject that the symptoms may occur in a variety of disorders, but most of the reported cases were evidently hysterical in nature as undoubtedly the cases under my care were. Many of the cases recorded show that the condition specially comes about when the patient is in a distressing situation and there seems little doubt that it indicates a flight in the imagination back to the happy days of childhood, to the safety and comfort of the mother's arms. One can well understand that in the terrible experiences of active service some psychopaths should develop this symptom as a reaction. It is surprising that there are so few.

I will now pass on to my survey of the psychiatric war work.

GENERAL PSYCHIATRIC CONSIDERATIONS

In dealing with army psychiatry one must bear in mind that we have to some extent different human material than in civil life. There is to a large extent an age limit, mainly from 18 to 40 years, and within certain limits we have in the service men who have been through some sort of recruiting examination, and so presumably a good many mentally unfit are thus eliminated. We have, then, a large body of the male sex only who all have to adapt themselves to more or less the same environment and experiences. In civilian life there is a greater variety of age, individuals, and environment. From this we may deduce the fact that some types of psychoses will not be commonly met with and that the special circumstances involved in war will tend to bring about types of mental reactions not so frequently seen in ordinary life. One must bear in mind that the mere fact of removing an individual from his civilian occupation, taking him out of an existence where within wide limits he has so great liberty of thought and action and placing him in so different an environment in which he finds an unaccustomed iron discipline whereby he has his freedom at once almost entirely curtailed, tends by itself to engender mental reactions which may be abnormal and especially so in those who have a psychopathic constitution. Before the Commission which sat to enquire into the recruiting problems, in the evidence given by the Military, the opinion was freely expressed that if a man was fit enough to do any form of work in civil life, he was fit to do that work in the Army. Never was there a greater fallacy. Large numbers of cases which have been returned from overseas with psychopathic symptoms freely illustrate the falsity of this statement. The mental factor has not had anything like the consideration it should have received. One can formulate few rules on such a point. Every case should be treated on its individual merits. If there be any evidence of mental maladaptation in civil life, how much greater will the probability be of such under the complex conditions of military life, and still more so in actual warfare.

One can readily understand that in discussing the etiology of war psychoses one has to take a very broad outlook, for the various factors which may predispose and be directly or indirectly causative are manifold and complex. War psychiatry is almost a new study. During the years of modern medicine the soldiers taking part in active warfare have been more or less trained and picked men and for the first time the civilian population has been more or less suddenly called upon to fill the ranks of large armies. The conditions of warfare too have suddenly changed so much. Enormously high explosives, poisoned gases and flame fire have been added to the army's armamentarium, while bombing from the air and the peculiar methods of trench strategy have added so greatly to the mental and physical strain of the combatants. Except for some psychiatric publications by Russia in the Russo-Japanese war, the only literature on military psychoses has previously treated of the findings in time of peace. Richards,[20] tells us that it was in the Russo-Japanese war that for the first time in the history of the world mental diseases were separately cared for by specialists, from the firing line back to the home country. Some detailed statistics thus come to hand which I do not purpose to discuss here, but only draw attention to the surprising statement that 22.5 per cent were said to consist of epileptic psychoses and to the fact that 19.5 per cent were stated to be alcoholic in origin.

In considering the factors tending to bring about the mental breakdown, one should, I think first bear in mind the point I have already alluded to elsewhere, that is, that the necessary abnegation of free thought and conduct, combined with the fact of becoming subject to an unaccustomed iron discipline, is sufficient, especially in the psychopathically disposed, to produce mental reactions of an unhealthy type. Such reactions must be helped on, too, to a great extent by associative factors, the leaving of home and those near and dear to them and in many cases dependent on them, the blighting of ambitious hopes in civil life, the fear of financial ruin, the loss of business and may be the dread of future incapacity or loss of life. Doubtless the herd instinct with the average man tends to overwhelm these incapacitating thoughts and feelings and the "crowd emotion" gradually but surely begins to fill him with martial and patriotic sentiments, so that before long he is straining hard to be an efficient soldier and even longing to come to grips with the foe. Nevertheless, many experiences may render him individualistic again, and it is then that mental conflicts are set up which in the predisposed may result in psychopathic reactions. Should he have had previous mental breakdowns his outlook in any circumstances is worse, but he is usually ashamed to mention the fact at the time of medical examination and even when known to the authorities the fact is often ignored. I have had a man under my care whose history sheet was marked under the heading of "slight defect," but not sufficient to cause rejection: "Two previous attacks of insanity." Generally one hears of psychoses as tending to be brought about by *stress and strain* of warfare. So vague a term would comprise mainly the factors of mental and physical exhaustion, and climatic conditions and *per se* would not produce mental disturbance probably without other issues being involved.

In my opinion the so-called *exhaustion psychosis* requires much pathological investigation. Intense physical exhaustion alone can produce no psychosis. The war correspondent of the *Daily Chronicle* wrote, April 3, 1918, concerning the men who had fought for six days and nights: "They were almost tired to death, and when called on to make one last effort after six days and nights of fighting and marching, many of them staggered up like men who had been chloroformed, with dazed eyes and grey and drawn faces, speechless, deaf to words spoken to them, blind to the menace about them, seemingly at the last gasp of strength. Towards the end of this fighting they had a drunken craving for sleep and slept standing with their heads falling against the parapet. In body and brain those men of ours were tired to the point of death.

They felt like old, old men, yet after a few days rest they were young and fresh. It was almost impossible to believe they were the same men. They had washed off the dirt of battle and shaved, the tiredness had gone out of their eyes, and their youth had come back to them." This graphic description pictures very vividly how the extreme limit of exhaustion had been reached and yet a few days rest and all was well with them. If intense exhaustion produces chemical toxins, which, acting upon the nervous system is said to bring about a confusional psychotic state, how can we explain the fact that the experiences written above are quite frequent and yet these men retain their mental health? It is very possible that some lowering of resistance may be left which may predispose the men to a later breakdown, but it is very doubtful if even that would occur without some definite psychogenetic factor. Birnbaum has pointed out that pictures similar to the so-called exhaustion states often occur "solely in consequence of psychic shock, as symptoms of frank psychogenetic disorders, and that there is much to suggest the purely psychic origin of these disturbances in war." Bonhoeffer,[21] was unable to find evidence of exhaustion psychoses as the result of warfare and he states: "A collective survey of war observations demonstrates the great power of resistance of the healthy brain and the insignificance of both exhaustion and emotional factors in the development of actual mental diseases." With regard to the exhaustion, I certainly concur, although the question of the emotional factor is very open to question. Aschaffenburg declares he has seen no cases in which any psychic disturbance worth mentioning has resulted from exhaustion. Clarence B. Farrar concluded from his observations on Canadian soldiers that "the factor of exhaustion may lead to collapse or to acute transitory fatigue states, and if severe and protracted to progressive, physical deterioration. War experience has not established its etiologic importance in the neuroses or psychoses."

For some reason or other the diagnosis of exhaustion psychosis has been added of late to the official nomenclature of mental diseases. This may be harmful in that it may lead many to use this term heedlessly and encourage others not to look further for deeper and more important factors.

The question of *climate* calls for no special mention as it is only part and parcel of the general hardship that a soldier has to undergo, except in the Eastern campaign where heat stroke, sun-stroke and allied conditions do undoubtedly tend to lower mental resistance. Many of my cases with variqus psychopathic symptoms, but more especially those who had been in confusional states, blame the heat largely for their breakdown. Whether this was a rationalization or not, I am not in a position to say, but I should be inclined to place heat in the same category as exhaustion, that is, as only being contributory.

Acute illnesses were predisposing and contributory as well. In the East there were many cases of nervous and mental trouble brought on during, or as a sequela to, malaria. The toxin of this disease seemed to have quite a predilection for the nervous system, and amnesic states were quite frequent in its train.

Physical traumata such as head wounds and concussion may lead to the exhibition of mental symptoms through definite interference with, or destruction of, cerebral tissue, and following on such injuries many anomalous states tend to occur. Fugues, amnesias, character changes and convulsive attacks were those mainly seen. We know comparatively little of the pathology of these post-tramautic states, but it is probable that the loss of inhibition brought about by the trauma, thereby permitting latent tendencies and instinctive trends to gain control, is the basis of them. Many authorities regard pre-existing *syphilis* as a marked predisposing cause to nervous and mental diseases in times of strain. I cannot personally say whether this is so or not and the point is a very difficult one to decide. Even if the Wassermann test in a patient be positive, how can one show that this has any real relationship to the psychosis?

Alcohol is of more importance. Although I can only trace a comparatively small percentage of cases to its influence, there are some who take a very opposite view. Lepine,[19] makes the astounding statement that alcohol was the primary and sole cause in one third of his cases and more than half, perhaps two thirds, were influenced by it! His data were based upon 6,000 cases, but is is difficult to see how he could come to such a conclusion. If his deductions are true, one can safely say that the cases met with in the British Army are very different. I am not in a position to give the percentage in my cases at present but I know the ratio is very small. In the Russo-Japanese war the percentage was very high, according to Gerver, and accounted for one third of all the psychoses. He claims, however, that in the last Russian campaign the number of psychoses was comparatively small and that the decreased rate is due to the total absence of alcoholism, not a single case of alcoholic insanity having occurred. Without knowing more of the conditions under which the Russian soldiers were placed, one cannot draw any hard and fast deductions, but the fact as stated is worth recording. From my point of view, the question of alcohol in the causation of mental disease requires much reconsideration. Apart from the acute intoxications and those chronic states induced by many years of excessive imbibing producing a demential condition, I regard alcohol as only a side issue working with and aiding mental conflict. The drug is so often taken as a narcotic to try and drown a conflict which is either conscious or in danger of becoming so. Alcohol tends to remove inhibitions, aids mental regression and in the end psychological mechanisms are set in motion which mostly bring about the result of having saved the individual mental pain. The effects are compensatory. What would have happened if the alcohol had not been taken? Fenenczi[22] says: "The one-sided agitation of temperance reformers tries to veil the fact that in the large majority of cases alcoholism is not the cause of neuroses, but the result of them and a calamitous one. . . . When alcohol is withdrawn, there remains at the disposal of the psyche numerous other paths to the 'flight into disease.' And when psychoneurotics suffer from anxiety hysteria or dementia praecox instead of from alcoholism one regrets the enormous expenditure of energy that has been applied against alcohol but in the wrong place."

In more or less superficial statistical work it is difficult to make sure as to the absence or not of the alcoholic factor, but in my experience in the war psychoses it is not a glaring one and when present is constantly found not to have been a main issue. Precisely the same syndrome may be met, with or without alcohol as an adjuvant. One must not take up much space here in discussing this interesting problem. The topic will be touched on again later in speaking of the clinical material itself. There only remains to mention *mental conflict* as the last but most important etiological factor in the production of the war psychoses. Now that modern psychiatrists are more and more studying the psychology of mental diseases, they are tending *pari passu* to find mental conflicts as the *fons et origo* of the psychoses. The mechanisms involved, the distortions and disguises which those same mechanisms have brought about, and the end results in more or less definite clinical types have been much studied and formulated in dementia praecox, manic-depressive insanity and paranoidal states. Further research reveals now psychogenetic factors in many of the so-called alcoholic psychoses, in epilepsy, hallucinatory deliriums and prison psychoses. We understand now to some extent that the aim of these psychological mechanisms is constructive and that the patients thereby have defended themselves against internal warfare, have built a world of their own in which they feel they can live, and have in many instances obviated mental pain and self-reproach and gained their compensations.

In warfare we should not be surprised to find great opportunities for mental conflicts. The battle within between the highest desire to follow the dictates of duty and honour, and the individualistic wish for safety and to be out of it all, is a conflict that must occur at any rate now and again to almost every combatant. News from home of a disturbing nature, the separation of loved ones and the unfaithfulness of wives cause worries that one hears of in case after case of mental trouble.

Exhaustion and indisposition, rendering the sufferer less able to work properly, tends to bring about morbid feelings of incompetency, unworthiness and impotency. Enforced sexual abstinence in some, causes anxiety; promiscuous intercourse, self-reproach, and I believe that the sole male communionship in many, lights up a latent homosexuality which, though perhaps never becoming conscious, produces a mental conflict and, may be, a paranoidal state. Of course mental conflicts can produce no psychosis if resolution takes place normally, but through repression and abnormal resolution, havoc may be wrought and especially in those whose mental soil is fertile.

I am convinced that in a large number of instances alcohol is freely taken to narcotize these conflicts which might or might not have produced psychopatic symptoms without its use. As I have stated before, even in those abnormal states which follow upon physical illness, trauma or exhaustion, there is good reason for believing that a psychogenetic factor is present and brought to the fore by a failure of repression caused by the temporary loss of inhibition. Let us pass on to consider some points of the various mental reactions we find in the war psychoses.

At "D" Block, Netley, which is only a Clearing Hospital, every expeditionary force officer, N. C. O. and soldier from every theatre of war, France, Belgium, Italy, Salonica, Egypt, Mesopotamia and Palestine is admitted, examined and then sent on with a full report of his case to one or other of the British Mental War Hospitals where he remains, if necessary, for nine months before being certified as of unsound mind and placed in an asylum as a special service patient. Since the outbreak of war a large number of officers and men have been admitted. Of these men about 60 per cent had been under fire and about 40 per cent had not been under fire. A certain proportion had previously been inmates of Asylums. The average length of stay of each case in this hospital is only a few days, so that any deep study of the individual cases has been out of the question; but what one has lacked in this respect is to some extent compensated for by the large numbers and wide though superficial outlook gained.

I have made statistical notes on 3,000 consecutive cases whose clinical careers I have followed up. Later I shall publish my findings and deductions therefrom. In this present short survey I purport only to make a few remarks under the headings mainly of reaction types. It is a futile proceeding to endeavour to fit each case into some text-book type. That only leads to much scientific inaccuracy, for few observers would agree in so many instances as to what particular label should be tacked on. Greater knowledge leads to improved diagnosis and greater difficulty in labelling. Officially, all cases must be returned according to a hard and fast nomenclature full of errors. This unfortunately will render official statistics practically valueless.

Perhaps the first thing that would strike the average observer if he saw a collection of mental cases from overseas would be, I think, the outward and visible signs of general *mental deficiency* as depicted upon the faces he saw before him. Though facial expression and features are but poor and superficial guides in this direction, in the main, he would be right in his assumption that a very large proportion of the men had a subnormal mentality. It is true that the expression of those who are confused and apathetic tends to lend the countenance an appearance which is deceptive. It is surprising how, when the confusion disappears and more interest is taken in the environment, the previous impression of intellectual defect vanishes at the same time.

I am inclined to think that the question of mental deficiency—using the term in a wide and scientific sense—is one of the most important with which the recruiting authorities have to deal.

When my statistical studies are published, this point will be seen very definitely. Yet there are many issues connected with it which at first may not be thought of. It is astonishing to note the length of service of some of these men who arrive home with reports of their uselessness and their having been a danger to themselves and others. But on tracing their history one finds that so many were never permitted to use a rifle and for a long period of time had only been performing menial duties and had only perhaps broken down when the slightest responsibilities were given them. The difficulties of invaliding a man home under the heading "mental deficiency" may be, too, a reason for their remaining in service so long. A large number of such men are incorporated in the Labour Battalions, where it is presumed that a mental defect is of small account. We here see the idea carried out that if a man can do any work in civil life he can do it in the army, and can do it overseas. Unfortunately though, practice does not bear out any such theory as any psychopathologist would have predicted. Poor-witted farm labourers who have lived in the most simple surroundings all their lives cannot adapt themselves for long in an army organization and still less so when having to work under shell fire. With the games their comrades play upon them and the stern treatment meted out to them by their N. C. O.'s, is it any wonder that they develop some confusional symptoms, that they get persecutory ideas (which often have some true basis), and show stuporous and other psychopathic states?

Mental adaptability is something that one cannot weigh in a balance, measure in mathematical terms, or predict with certainty. How hard it is to prognosticate on such a question is shown by the surprising number of mental defects who *do* somehow or other adapt themselves normally for a surprisingly long time. One can therefore have some sympathy with the military authorities if they take up the attitude that they require the services of every available man, that no one can say with any certainty how long a certain type of mental defect may be useful and that it is worth their while to risk recruiting a man on the chance of his being able to serve for some fair period of time.

The psychiatrist sees only one side of the picture and it is possible that perhaps he takes a too academic point of view. Nevertheless one would be fair in saying that recruiting authorities are far too careless generally in this and in their attitude towards the neuro-psychic constitution of the men brought before them. One must bear in mind that this has an important bearing on the swelling of the already enormous pension list which might have been to some extent obviated.

Many of the cases are found to be purely mental defects from fairly low grades to morons, while many others on this basis have superimposed symptoms. Some amount of confusion with memory defect is perhaps the commonest type met with, but transient excitements, depressions and delusional states are met with as well. Dementia praecox may complicate the clinical picture; while temporary paranoidal symptoms are very apt to colour any abnormal state that may be manifested. It would serve no useful purpose to go in to any further detail here of the psychotic conditions found. The medico-legal side of the defect is of importance. As may easily be imagined, these individuals are fruitlessly and constantly punished for minor delinquencies and only later are found to be, at any rate, partly irresponsible.

The various types of mental reaction may be considered under the headings of confusional, depressive, excited, paranoid and anomalous mixed types.

The Confusional States are extremely common, and it is because of this fact that it has been superficially supposed that some exhaustive factor must be the causative agent. Unfortunately the opportunity I had of studying my cases was so meagre because of their short stay at Netley that I should not like to express any definite opinion as to their pathology. The types met with vary so much that classification becomes difficult if not impossible, and certainly the majority do not conform to any text-book description. A certain number of cases are patently due to toxic influence and follow upon definite bodily illness. As I have already mentioned, the malarial poison was a common offender, and every convoy from the Eastern sphere of war contained some patients suffering from a mild confusion with which frequently a more or less severe amnesia was shown. These usually had been acute or sub-acute at the onset and had become somewhat chronic. A few presented themselves in almost stuporous conditions. The acute confusional states differed in no way from those seen in civil life but, without a definite causal history, it was impossible to say whether the case would prove to be one of dementia praecox when the acute onset had subsided. More or less acute hallucinatory states were brought about more especially after psychic shocks and presented the symptoms of an acute hysterical dissociation which were generally only of quite a temporary nature. Traumatic cases such as the concussional, showed nothing special, but, as with nearly all psychotic symptoms, there would be a war colouring to the picture. We may truly say that the various types of confusion are often wrapt in obscurity as regards their pathology, and the war literature up to the present hardly throws any light on the subject. Mallet,[23] devotes an article on it, but his findings do not lead us far. Charon,[24] states that there was no astonishment at the different varieties of confusion seen in war patients because of the prevalence of the alcoholic factor. This point has been dealt with before and more than seriously called in question, at any rate where British troops are concerned. Toxic factors are probably accountable for many cases, but what these toxins may be is by no means often obvious. Many confusions are undoubtedly purely psychological in origin such as those we see so commonly associated with mental deficiency. Maladaptable mentalities when called upon more or less suddenly to face difficult and new situations will naturally react in a confusional way from conflict of impulse. At times what is taken for confusion is really a dream state resulting from an inherent desire to negate reality.

Dementia praecox as might be supposed, accounts for a very large number of the psychoses of war. It is often impossible to be certain that this condition exists, until prolonged observation has taken place, as so many other of the mental reactions of war are akin to it. One sees so many cases in which there is marked apathy as a leading symptom that, in the absence of other diagnostic factors, time often alone can be the test and especially is this so as the previous history of the patient is so frequently not obtainable. I have constantly been deceived in this way and other psychiatrists have had a similar experience. The different types—hebephrenic, catatonic and paranoid—have been met with as in civil practice. Nothing special can be said of these, but naturally the context of their delusions and hallucinations has often a military colouring.

It is easy to understand that *the depressive reactions* would be more in evidence than excited reactions since all the circumstances of the soldier's life would naturally bend more in this direction. The loss or diminution of the herd instinct must arise at times when the individual feelings come to the fore and introspection comes about with its morbid tendencies. Home worry is, one finds, a prevalent factor in the engendering of a mental breakdown even in those who previously had shown no psychopathic characteristics. The constant stern demands of duty, though hearts are sore and souls be in pain, must produce mental conflicts difficult of rational adjustment. As the emotions so largely in such an environment must be repressed, is it any wonder that many develop morbid symptoms? Depressive anxiety and morbid apprehension are seen in the milder cases and intense depression in the more severe. The feeling of diffuse anxiety and that some unknown harm is going to arise is so frequently met with that Lepine makes a definite class of these cases under the term, "anxious insanity" which he thinks more fitly describes them than melancholia. As in manic-depressive states generally, self-accusation and the symptoms of a morbid conscience are frequently in evidence, and not seldom can they be traced to auto-erotic associations upon which we know their pathology depends. It is an interesting and debatable point as to whether many of the anxiety conditions may not be due to ungratified sexual desire. One sees no reason why this should not be in some an etiological factor especially at times when inaction prevents the sidetracking of the energy. A very large number of depressions are only secondary to paranoid ideas. Some psychiatrists would not hesitate to place such cases in the manic-depressive group while others, including myself, regard the paranoid reaction as essentially primary and the depression only a natural sequence. This will be referred to later when I speak of paranoid cases. On the whole I find that the more typical forms of the depressive phase of manic-depressive insanity is not anything like as commonly met with among the war psychoses as one would expect. Because of the difficulties of exact classification and the differences of opinion on this point by psychiatrists, widely varying statistical results appear. The only British statistics published at present are those by Hotchkis,[25] who out of his 942 cases gives 133 as conforming to the depressive phase of manic-depressive insanity, i. e., about 14 per cent.

The excited reactions are comparatively infrequent compared with the other types. Hotchkis, out of his 942 returned only 31 as showing the manic phase of manic-depressive insanity. The manic cases, the acute confusional and the excited onset of a dementia praecox comprise the bulk of this type which calls for no special mention.

If I were asked whether there was anything special to note about war mental reactions I should unhesitatingly reply that a marked feature was the great prevalence of a *paranoid* trend. It seems to permeate into the clinical picture of a very large percentage of cases even where the outstanding features are widely different. It tends to colour the mental defect and the manic-depressive types, while in the dementia praecox case it is as usual a prominent early symptom, and is seen in full bloom constantly in a temporary acute pure paranoid psychosis. It may be that only a vague feeling of suspicion may be present or an indefinite sense that everybody is against them or it may develop still further into a definite brief unsystematized persecutory state. From my experience I would say that the soldier's environment and experiences tend largely to bring about this type of reaction. The psychological mechanism of projection is common enough in everyday life but seems to be brought into use as a defense reaction much more when under service conditions. The mental defect often has substantial ground for his persecutory ideas. He is bullied, made game of and tends to lead an existence which brings about the natural conclusion that everybody is against him. The whole trend of iron discipline fosters in some the idea of persecution which becomes exaggerated in a mind that is morbidly disposed and that has become individualistic. When duties are not performed satisfactorily the "bad workman blames his tools"; the soldier may take up a similar attitude. Morbid introspection leads to the arousing of old self-reproaches, conscious and unconscious, the resulting conflict ending in projection.

The history of a typical case is that the man is seen to become asocial and to avoid his comrades, to become depressed and to sleep badly. Casual remarks elicit the fact that he thinks everyone is against him and after a time he becomes persecuted by a definite group. He imagines he is regarded as a spy and an object of suspicion by every one. Hallucinations may or may not further complicate the picture. If they develop, the "voices" threaten to "do him in," to call him filthy and obscene names, and to accuse him of the most immoral acts. This condition of an acute hallucinatory paranoia is a marked war psychosis. In many instances alcohol enters into the history, and these states are usually regarded as alcoholic; but precisely the same syndrome is produced without the drug. I regard alcohol only as a side issue, aiding mental regression, helping to remove inhibitions and thus perhaps more fully precipitating the symptoms. It is often easy to see that it was because of the mental conflict that the alcohol was taken as a refuge and narcotic. These cases have a good prognosis and often recover within a few weeks with insight. The pathology of these cases requires much more elucidation. Freud and his school state that homosexuality is a basic factor in paranoid states. It certainly must be patent to any observer that sexual matters enter very largely into the hallucinatory content of these patients. Considering that this kind of psychopathic reaction is so common on active service, it would be suggestive to investigate the theory that the herding of men together in the army where heterosexual intercourse is mostly excluded, tends to arouse a latent homosexual trend against which the personality defends itself by "projection." That this hypothesis has some grounds for belief is not improbable. As Mr. A. F. Shand[26] truly points out, suspicion is an emotion which though so prevalent, has been curiously overlooked and neglected by psychologists in the past. There is here much interesting material for investigation in war psychiatric work and I shall look forward to see later what the American neuropsychiatrists have to say on the subject.

The more psychiatrists see of *general paresis*, the more they find that the diagnosis depends upon a study of the combination of the mental symptoms and the organic nervous signs, plus the blood and serological findings. In my Clearing Hospital it has not therefore been possible to be by any means sure of how many cases were passing through our hands. Superficially one found that one had made many wrong conjectures when the cases were afterwards followed up. It is a very debatable point whether the stress and strain of war does or does not tend to be a factor in hastening the advent of this disease. Authorities differ very much in their statements, some denying that active service has made any difference while others take precisely the opposite view. It is, of course a very difficult point to decide. Having not yet classified my 3,000 cases, I am not yet in a position to make any statements in this regard, but I have certainly been struck by the incidence of the disease at a very much earlier age than one usually sees in civil life and by the very short period existing between the contraction of syphilis and the commencement of paretic symptoms. In the Russo-Japanese War the percentage was 5.6 per cent. Hotchkis,[25] in his analysis finds only two per cent, and definitely states that the data on these cases do not justify an opinion on the part played by military service in bringing on the disease in the syphilitic.

Anomalous and mixed reactions of various kinds were met with which defied any definite scientific classification and a few psychoses resulting from gross brain lesions cropped up now and again. Though a fair number of epileptics were returned from the front, the number of epileptic psychoses were quite conspicuous by their absence. Epileptic confusion of a temporary nature was the main symptom seen. Many transferred home as cases of epilepsy were found on investigation to be really psychoneurotic in origin. It is curious to note that in the Russo-Japanese War epileptic psychoses were said to be as high as 22.5 per cent.

The so-called *alcoholic psychoses* have been mainly spoken of elsewhere. All one can say is that in many of the paranoid states an alcoholic history was obtainable and ordinarily these are classed under this heading. I do not think this is scientifically correct. Many modern psychiatrists are taking this view and regarding alcohol as an etiological factor in the production of insanity as overrated, incidence being confused with cause. The old text-book type,—alcoholic hallucinosis—requires its pathology remodeled. Important psychic factors are always present. Alcohol is not a necessary factor in the production of the psychosis, and usually the sensorium is clear and no definite toxic symptoms are observed. The acute intoxications, chronic demented states and Korsakow's syndrome stand in quite a different category· The question is ably discussed by Schneider[27], who quite endorses my views on the subject. One is tempted to pursue this highly interesting question further, but space forbids. Only a few acute alcoholic cases passed through my hands.

I would like before concluding to say a few words on *suicide* as met with under active service conditions. It is usually stated that different individuals tend to choose the means of suicide according to their occupation. Certainly there are excellent grounds for presuming that definite psychic factors aid in this choice and that mental analysis would often reveal the reason why drowning, poison, etc., specially appealed to the individual as a means of taking his own life. It is therefore an interesting point that the vast majority of soldiers use the razor for this purpose instead of the rifle which one would superficially suppose as the handiest weapon. I do not think either that the mechanical difficulties involved in using the firearm is sufficient to explain why it is so seldom chosen. The majority of suicides that have occurred have been among the acutely hallucinated paranoiacs, who, driven to desperation through the continuous accusing "voices" sought an end to their existence. There were comparatively few suicides among the pure manic-depressive or dementia praecox cases. This, I think, is partly accounted for by the fact that the latter cases were of slower development and so came under special observation and supervision earlier. A few suicides occurred in quite temporary confusional states and where one could trace no previous depression or find evidence of mental conflict. Among the paranoid cases the act was very often premeditated, but amnesia for the act itself and shortly afterwards was extremely frequent. Such memory gaps are common enough when certain antisocial acts are performed and they become necessarily of great medico-legal interest. The genuineness of the amnesia is by many called in question. I recollect being told that an eminent alienist, when called in by the Crown to decide the question of responsibility in murder cases and where amnesia was said to exist for the act, said he did not believe in those losses of memory and he decided the question by always having the victim hanged! Personally, I believe that a true amnesia often does exist, though doubtless the memory could be recovered by special means. The conscious personality itself would tend to inhibit the act, so that for the time dissociation takes place as the result of the mental conflict and the suicidal act is performed while in this dissociated state. It has the same pathological basis as the amnesic fugue. Suicide mainly involves the absolute negation of reality. It is the furthermost limit of that flight from reality, which to some degree or other is perhaps the most fundamental human trend. The psychology of suicide requires much studying. Most psychiatrists only take it at its surface value. Wholey[28] has made some highly interesting observations on this subject and especially as related to the alcoholic. In the article referred to he says, "The regularity with which we find the alcoholic attempting suicide by throat laceration lends confirmation to the theory that a 'birth phantasy' determines the manner of suicide. Such an interpretation of the psychology of the alcoholic is in keeping with the theory of his homosexual fixation. . . . It is to be noted that it is not the affect-depression of the melancholic which drives these patients to suicide but an overwhelming urge to escape from an imminent death attended by the most hideous torture and mutilation. . . . The alcoholic's 'torture' practically always includes mutilation of the genital organs." These ideas are extremely suggestive and mark a distinct advance in our conception of the pathology of suicide.

In conclusion, I would only draw attention to the lesson to be learned from psychiatric war work, that early recognition and treatment of mental disease brings about incalculable good. Under service conditions the soldier's abnormalities are quickly observed, with the result that he soon becomes placed in the best environment for his speedy recovery. The percentage of recoveries with us has been large. I hope that in the near future we may in England be able to adopt some such mental hygiene movement as exists in the United States. At any rate neuropsychiatry has a more hopeful outlook both for physican and patient.

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MENTAL HYGIENE AND SOCIAL WORK: NOTES ON A COURSE IN SOCIAL PSYCHIATRY FOR SOCIAL WORKERS

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PATHOLOGY is older than sociology, and medicine, i. e., applied pathology, has more triumphs in its history than has social work, i. e., applied sociology. Mental hygiene, a branch of applied pathology, is naturally dominated by physicians and by a special group of physicians, viz., psychiatrists. But is there a co-ordinate branch of applied sociology? Does the medical branch of applied sociology have a subdivision deserving the name psychiatric social work? Or, put pragmatically, is there a group of psychiatric social workers who have control of a field of "psychiatric social work" co-ordinate with "mental hygiene"?

The comparative youth of sociology, of applied sociology (social work[1]), of applied medical sociology (medical social work[2]), and of the putative new branch (psychiatric social work[3],[4]) entails a certain fluidity of nomenclature at first not unserviceable. Nor would it be necessary or even desirable to fix at the outset a nomenclature for logical compartments of an undeveloped art, as we might thus condemn the art to stasis or bad *culs-de-sac*. I raise the question, therefore, only on the practical ground of whether or no specialists, professional or technical, have been developed or are in course of development in this field of sociology. For, if so, that is, if the new art has found its shoulder-to-shoulder workers, then it is high time to state the principles of their alignment, and the nature of curricula and practical experience necessary for these workers.

I assume that medicine and applied sociology are professions with their professors and practitioners having due recognition in university degrees, M.D. and Ph.D., respectively, and in commonly accepted titles, *physician* and *sociologist*. On account of the recency of sociology's foundation, everybody is prepared to accord to many workers without the degree Ph.D. just as good and perfectly equivalent dignity. Nor should such a contention as that sociologists will more and more tend to be Ph.D. bearers be regarded as propaganda of Professor James' "Ph.D. octopus," since everybody is now aware that novelty, in medicine, sociology, or any other branch, is perhaps more likely than not to come from some distant science. Thus the teaching branches of medicine are more likely to get novelty from e. g., chemistry, or physics, than from their own more limited fields. And the teaching branches of applied sociology are very likely to profit more from anthropology or psychology than from the recognized rounds of sociological research as narrowly conceived, e. g., in the field of social statistics. Perhaps even it might be said that many branches of didactic medicine and sociology would get more food for new thought from each other than each from itself. We are not here talking of the technique of research, but of the sort of training which allows us to concede that such and such a person is entitled to rank as a professional sociologist alongside the physician.

There are, to repeat, persons to whom we accord an equal professional rank as didactic or practical masters of their fields—physicians and sociologists. But every professor must develop apprentices or ancillary workers of various sorts. Thus medicine has developed the *nurse*. Applied sociology, I make bold to say, has developed quite on the same level—the *social worker*. One has to be bold! For many social workers, perfectly modest as to their own private capacities, have developed a surprising group-consciousness concerning the proper dominance of the ideal social worker in all social maladjustments. This group-consciousness of social workers often leads to a not unwarranted derision on the part of physicians, judges, men of the world. The point here is probably simple: just because not every eminent sociologist is a Ph.D. and because many sociologists prefer to call themselves "workers" (from the American habit of denouncing theory and suspecting all 'ologists of carrying lugs), many humbler persons conceive that there is no theory behind their practice, no sociology behind their social service. It is as if on the one hand, physicians seeing that medicine is so much a matter of nursing should announce themselves as a kind of nurse; it is as if, on the other hand, nurses seeing that the physicians are so ignorant of many practical matters should suddenly conceive that nurses were after all a sort of physician. Practically, too, in the present phase of social service development, social workers are apt to be of a finer grain and a more finished higher education than the majority of nurses, and accordingly the social workers are inclined to develop a feeling of group-superiority to nurses. This attitude is of course a matter of dispute as to its justifiability, but is none the less existent. But I conceive that, unless a person wishes to go to the length of special training of professional grade, he can hardly claim equivalence to a man of professional training. I conceive that professionally trained social workers, of the Ph.D. level or equivalent, will finally admit themselves to be sociologists, albeit applied sociologists. And I hope that further there will be a group-consciousness developed of social workers below the 'ologist grade with an attitude resembling that of nurses to their work—an attitude, according to temperament, of humble pride or proud humility with respect to their acknowledged leaders. Nor should the term *profession*[6] be made a stumbling-block: if nursing is a profession, so ought social work (below the level of sociology) to be acknowledged a profession also; but this last is a matter of terms only.

We thus obtain the following comparisons:

Pathology	Sociology
Medicine (i. e., applied or practical pathology)	Applied or Practical Sociology
Degree: M.D.	Degree: Ph.D.—or equivalent experience
Practitioner: physician	Practitioner: applied sociologist (more modest titles or special titles usually assumed)
Auxiliary: trained nurse	Auxiliary: trained social worker

Up to this point, I think, all will agree who have looked into the facts of actual progress in the two fields. Considering the relative novelty of sociology, we can only regard it as very striking that the practical social worker has so soon taken her high place in the world alongside the nurse.

But no two sciences or arts can in these days long exist without fruitful contacts. Pathological and sociological progress have gone hand in hand. Many a physician is, we say, really and by temper a sociologist; many a sociologist develops so deep an interest in, e. g., sanitation problems that he becomes in effect a physician, at least an expert in public health. Social medicine and medical sociology have much in common: either could receive the term *theory of the public health* without special error of definition.

Not to linger over the definition of public health, hygiene, and preventive medicine as against the non-medical branches of sanitary science and art, it is clear that both social medicine and medical sociology have brought to life auxiliary groups of practical workers, viz., the *public health nurse*[6] and the *medical social worker*. It is clear, too, that, just as social medicine and medical sociology are different in their points of view, so the aides in the practical work of each field are likely to have a different point of view. If the lively growth of the public health nurse group sometimes threatens to engulf the medical social worker (e. g., by proposals that the same curriculum will do for both), the fact is that no such forced union will ever take place, judging by the quality and nature of the persons each field has so far attracted.

Assuming certain differences between the public health nurse and the medical social worker, I want to press to another inquiry, whether the art of mental hygiene, taken either as part of medicine or as part of sociology, has the right to think of establishing its own auxiliaries, i. e., by a kind of differentiation of nurses on the one hand and of medical social workers on the other.

Now it is obvious that the public health nurse of today is no better prepared to be an aide to a psychiatrist than the ordinary physician is trained to deal with psychopathic cases. Should there not be a new group of nurse-like human beings who should be aides to psychiatrists in much the same sense as public health nurses are aides to the public health physicians? On the other hand, should not there be a special group of medical social workers skilled in the psychiatric side of medical sociology? Or will, perchance, these two kinds of auxiliary be identical, both as to the timber we choose to develop and as to the curriculum we lay down?

Another parallel column array may clarify the issue:

Physician, M.D.	**Sociologist, Ph.D. (*et al.*)**
Trained nurse	**Trained social worker**
Public health nurse	**Medical social worker**
Psychiatric nurse	**Psychiatric social worker**

The point raised is whether either or both of these last-mentioned auxiliaries should be developed and, if something of the sort is desirable, whether the training of these mental hygiene aides ought to be specially conceived *in re* curriculum and experience.

Every psychiatrist, nay every man of the world, is familiar with nurses and social workers (even medical social workers) who would manifestly *not* do either as trained aides in mental hygiene or as timber for such. On the other hand, everybody knows a few persons, whether nurses, social workers, or just human beings, who admirably fill special requirements in the mental hygiene of some situation or would probably soon become fitted for such work. We think of sympathy and firmness, adaptability and steadfastness, quick insight and profound commonsense, modesty and knowledge of the world, and always and forever tact without prevarication, as desirable qualities for these persons. People in general ought to have these qualities too; but we want them more intensively still for our proposed mental hygiene aides. How wonderful, we opine, would it be if we could only reproduce by the scores and hundreds that particular nurse, social worker, clinic manager, companion, usher, secretary, clerk, psychological assistant, probation officer! Oh, if the world were better stocked with persons of such understanding! Alas! we are inclined to believe, the real mental hygiene aide *nascitur, non fit.*

I have recently given two sets of lectures to social workers on what I termed social psychiatry. They were given at the instance of the School of Social Work in Boston and the topics were chosen, in consultation with Miss Lucy Wright, Associate Director of the School, which is a department of a college for women, Simmons College. These lectures are my excuse for a psychiatrist's taking a few plantigrade steps in the garden of social work.

In the parallel columns above we found ourselves endeavoring to contrast at every turn the work of the physician and his aides and the work of the sociologist and his aides. Yet when we came down to the practical question—whether there might be developed a special group of lay aides and advisers in mental hygiene—we found ourselves reduced to acknowledge that perhaps these persons are born, not made.

All through the preparation for lectures on social psychiatry and especially in the discussions themselves, sundry rather profound differences in point of view seemed to stand out in relief, making it appear as if the trained social worker would not as such readily grasp the point of view of the mental hygiene aide. I have placed some of these differences or tendencies to difference in parallel columns.

Mental Hygiene (taken as a department of medicine)	*Social Work* (taken as a department of sociology)
Primary aim: aid of individual	Primary aim: aid of community
Tends to sacrifice community for individual	Tends to sacrifice individual for community
Tends to sacrifice family for individual	Tends to sacrifice individual for family
Hesitates to place patient in an institution	Overreadily suggests placing patient in an institution
Overoptimistic for the individual, overpessimistic for the community	Overoptimistic for the community, overpessimistic for the individual
Underrates effect of environment upon patient	Overrates effect of environment upon patient
Overanalytic and apt to consider task done with analysis	Oversynthetic and apt to rush into premature conclusions
Has little confidence in legislation as panacea	Loves to devise stiff legislation

But is it wholly fair thus to parallel mental hygiene and social work? For above, did we not contrast social work (that is, applied or practical sociology) with medicine (that is, applied or practical pathology)? We did not co-ordinate social service with mental hygiene as divisions of study and practice on the same level. Might it not be that social work, though its primary aim is the aid of the community, will find somewhere within its scope sufficient play for the individual's advantage also? Though social service tends or seems to tend to sacrifice the individual for the community, may it not be that somewhere within the scope of applied sociology the individual will be rescued? May it not prove possible to aid the community without sacrificing the individual, at least the so-called normal individual? In brief, by isolating mental hygiene as a subordinate department of medicine, have we not at the same time narrowed our issue so far, for the purpose of bringing the individual into the centre of the stage, that a wholly artificial contrast and distinction has been set up between mental hygiene and social service?

We shall in the sequel, I think, become certain that the practical aims of mental hygiene and of social work are largely identical. Yet it appears to me that they will always remain not wholly identical. It appears to me that the claims of the individual as such are not only logically, but also psychologically and practically, distinct from the claims of the community. In short, I think it will be possible to show that the point of view of medicine and the point of view of social work are at bottom sundered from each other, so that the physician and the sociologist, the nurse and the social worker, the mental hygiene aide and the psychiatric social worker, will always remain persons with somewhat separate sentiments. It is worth while to insist that these sentiments though separate are not necessarily opposed to one another. It is even possible that within a single personality a worker can be an effective individualist, on the one hand, and an effective social-groupist, on the other; that one can be both a physician and an applied sociologist successfully; but the success attained will probably be like that in which the right (or medical) hand, will not know what the left (or social) hand, is doing. It is my belief, though this is not the place to expound such, that the entire point of view of medicine is at bottom individualistic, though mental hygiene taken as a subordinate department of medicine is even a little less individualistic than the rest of medicine. I feel that, theoretically at least, the physician is often ready to sacrifice both the community and the family for the sake of saving, prolonging, or sweetening the life of the patient. It is my judgment, also, that the majority of physicians will be found holding most of the points of view listed in the column under mental hygiene above.

One cannot help noting, as above mentioned, that mental hygiene is on the whole a little less individualistic than the rest of medicine, and that, by the same token, the medical branch of social service, and especially the psychiatric subdivision thereof, is a branch of social work in which the individual's advantage stands out a good deal more than in social work at large. The unit of interest for the physician is the patient; the unit of interest for the social worker is the family. The unit of interest of the mental hygienist remains primarily the individual patient, but on account of the important public and social relations in which the individual patient stands, the mental hygienist must perforce see the patient in the midst of an entourage. The mental hygienist must confront, even more than the physician at large, that somewhat mysterious entity known to the older sociologists as the *Socius*. Per contra, the psychiatric social worker is apt to forget the community somewhat, to forget the milieu, and to see the small entourage of the patient's family dominated by the psychopathic figure in its midst. Now, whether you come at the situation as a mental hygienist and see the psychopath only a little more clearly than his entourage, or whether you come at the situation as a psychiatric social worker and see the entourage only a little more clearly than its contained psychopath, amounts to a pretty tenuous distinction, at all events when it comes to action. The mental hygienist has left behind the merely medical matter of diagnosis, prognosis, and treatment of this particular case shelled out of the family group, and the psychiatric social worker has almost, if not quite, forgotten that such a unit as a community exists. In short, it is almost all one whether the mental hygienist takes the psychopath as his unit of interest, and the psychiatric social worker the family as the unit of interest. The real point lodges in the relation between the psychopathic figure and the other figures in the family entourage. At this level of discussion, the mental hygienist would scoff at the thought that he tended to sacrifice family interests to individual interests, and the psychiatric social worker would alike deride the notion that the individual's interests were being sacrificed for those of the family. Time was when I should have thought the drawing of this distinction superfluous and the idea depicted a truism. However, in the course for social workers which gave rise to these notes, I found that the differentiation of these two points of view was a very live issue; and upon turning to sundry works upon sociology and community work, I am only strengthened in the conclusion that clarity upon this point—as to the actual unit of interest in sociology—is not readily achieved. It does not do to say that the distinction is licked up and vanishes in a higher unity; for that higher unity invariably turns in most modern books on sociology into the community. In any case, whatever the ultimate truth, it is important for the social worker to get at the point of view of the physician for the sake of mutual, practical understanding.

Many card-catalogues in social agencies employ the family as their unit, the family being as a rule an entity which is somehow economically at fault. But when it comes to medical social service, and especially to psychiatric social service, I am inclined to think that the card-catalogue unit ought to be the patient and not the family.

The first of the two sets of lectures to social workers was given to a selected group of advanced workers, who engaged in more or less free discussion as to the distinctions just drawn. I am not sure whether the existence of a field of mental hygiene as distinct from that of psychiatric social work was conceded by all my hearers; but if the existence of two points of view and two angles of approach to the same mass of material was allowed, much I think was accomplished. At any rate, I think there was no doubt in the minds of the listeners, that a field of psychiatric social service existed distinct from medical social service as a whole. I think it became plain that schools for social work or philanthropy, or under whatever name they may masquerade, should specialize their training for advanced workers more than has been customary in this matter of social psychiatry. Whatever doubt there may be as to the nomenclature of these fields, there can be no doubt, and especially in view of the social service hopes engendered by the war, that new tasks for expert propagandists are popping up on every side. In such a journal as MENTAL HYGIENE, the expert propagandists ought to exchange counsel and prepare for the popularization that must come in subsequent years. The war considerations permit us to take up a good deal of slack in the program; for in the war stress, nothing flaps and dangles as it seemed to do a few years since. Anybody's nomenclatural suggestions are thrown at once into tense looms at Washington and, lo! "neuropsychiatry," "neuropsychiatric experts," "neuropsychiatric units," get born or at least christened. How long it might have taken without a war to tie clinical neurology and psychiatry together thus closely is impossible to say.

The term *mental hygiene* itself, one had to maintain with the social workers, was a good term. Even its apparent vices could be shown to be merely unevolved virtues. The term *hygiene* had of course been commandeered by the public health movement, which styled itself a movement for hygiene and preventive medicine; yet it was not at all clear that the term should have been commandeered for physical considerations only. To be sure, the hygienist of the epidemic-preventing and sanitary group is apt to have a feeling of confusion and impotence when confronted with the term *mental* hygiene. Ten to one, such a physical hygienist has never looked at the economics of even the insanity problem (that small corner of the whole field of mental hygiene); or, if he has looked thereat, the huge state costs of committable mental diseases, dwarfing the costs of the physical hygienist's own field, are likely to be dismissed with the thought that insanity belongs somewhere with death and taxes—a necessary evil and drag upon civilization, bound to remain at about the same level or even to increase and get beyond public control. The vision of preventive *mental* hygiene is hardly obtainable by the physical hygienist of the day.

There is, of course, one comfort in the neglect of mental hygiene by public health workers. The mental hygienists themselves will have none to blame except themselves if their field is not cultivated aright. We remain in a horticultural and not an agricultural phase in mental hygiene as yet. Let us not develop a *hortus siccus* of

Leaflets for the Lazy
Blessed Don'ts for Blue Devils
Buried Memories and the Need of Careful Exhumation
Attitudes to Adopt toward New Ideas
Efficacy of Courtship under Medical Supervision
Can the Feebleminded Really Become Bankers?
Thomas Jefferson versus Alfred Binet
Something to be Said for the Bolsheviki.

Possibly these titles but remotely suggest the so-called "healthgrams" of the day, but I am sure that no mental hygienist is quite ready to institute a mental hygiene program consisting chiefly of punch.

In order practically to bring out the individualism of mental hygiene as contrasted with the family-groupism and community-groupism of social work, the technique adopted in the courses on social psychiatry here discussed was to demonstrate in skeleton form the histories of a number of intensively studied social service cases from the Psychopathic Hospital group. They were largely supplied from special studies by Miss Mary C. Jarrett, and a large minority of them had been published in various papers from the Psychopathic Hospital.[7-14] For the purpose of these courses, however, the cases were grouped and studied in different ways. In the first place, cases were analysed from the standpoint of a triple division of mental hygiene into public, social, and individual problem groups. I have discussed this tripartite division of mental hygiene in a previous paper,[15] and will here recall only that the distinction follows one of Dean Roscoe Pound in his chapters on sociological jurisprudence, drawn between the interests of organized government, on the one hand, as against unorganized community interests on the other, both being opposed to the interests of the individual. It was easy to show in the skeleton analysis of social service cases how public, social (in this narrow sense of non-governmental), and personal interests came into play. It was easy for the social worker, on logically separating out the public aspects of the case, to catch the point of view of the judge, the hospital administrator, and the legislator, and the immigration authorities, in certain instances. Again, in other instances, by the pure process of separating the personal aspects of the case out from the social and public, it was quite possible to get an angle wholly different from the ordinary social worker's angle. It became easy to see how circumspect must be the management of a case with public aspects, how delicate that in a case with personal difficulties. The psychiatric social worker was thus taught to see what the mental hygienist starts with knowing, namely, that a large number of problems in social psychiatry cannot be left to the management of the social worker, since the heavy hand of organized government and administration, and the filigree psychic interior of many a personal situation interpose. The technique of handling judges, on the one side, and physicians, on the other, without prejudice and with due consideration of authority, can be simply taught by means of this tripartite distinction of the problems of social, psychiatric, and mental hygiene into public, social, and personal.

Group { Public
Social } Private
Personal

Valuable as the tripartite distinction—public, social, and personal—often is, for other purposes we need to distinguish public from private (private including non-governmental social matters as well as personal ones), and we need to distinguish group matters from personal ones. The distinction "public versus private" has in applied sociology far less range than in jurisprudence; but the distinction between group and personal matters is in the forefront of most works on sociology. Works on ethics also are apt to deal nowadays with group ethics rather than with the ethics of the individual.

As mental hygienist, it was my duty in these lectures to lay more stress upon personality than upon the properties of the social group. It proved clarifying to recall to my hearers the truism of psychology, that every personality is itself in some sense a group. I used for the purpose the familiar distinction of the spiritual, material, and social—selves of William James—and used his grammatical distinction of the Ego and the Me. Leaving out the social self or social Me as a group concept, I pointed out the value of some distinctions, drawn by James in his famous chapter on the self, between the Ego and the material Me. The figure of speech, if it be such, which contemplates the material Me as now and then in control of the Ego, is particularly interesting to the social worker, familiar with the concept of group ethics; and the metaphor of the personality at war with itself, if it be a metaphor, is becoming a familiar one with all the modern work on mental conflicts—the new branch that we may call psychomachology. When the approach is made to these penetralia of psychology, it becomes easy to insist that the obvious thing is not always the right thing to do in a psychopathic situation.

Social workers should not always rush in where psychiatrists fear to tread. This matter of the relations of the patient to himself (quite too simply dealt with in the metaphor of the Ego and the Me) I have expounded to a slight extent elsewhere.[16] The whole grammatical point of view is doubtless too simple to account for much of the whole problem. Still I found that the concept of the *passive voice* proved an interesting one to many workers. The social worker often confronts a family with a more or less psychopathic figure objectively dominant in the scene. I say objectively dominant because the disturbing figure himself may be from his own point of view a depressed person quite in the passive voice. He may be even a rather violent feature of the situation, and may objectively do many dangerous and destructive things; yet upon analysis of his psychic interior, the situation may prove one, for the psychopath himself, of the passive voice. This key to the psychopathic situation may be quite missed by the social worker, who judges only by the obvious violence and destructiveness of the man's actions. The caged lion is objectively active and letting loose a good many foot-pounds of energy, but he is nevertheless a lion caged, and from his own point of view in the passive voice. The proper therapy from the lion's point of view would not be to anesthetize but rather to uncage the lion. Again, the foil to this situation occurs when the psychopathic figure in the family situation is to all outward observation an inoffensive quietistic person—who however refuses to work! Such a man, though objectively inactive, is sometimes subjectively extremely active; he is so far as the family is concerned, playing 'possum as to work. He is not at all in the passive voice, from his own point of view, but is actively dominating his environment.

These suggestions must suffice to indicate the value of an analysis of psychic situations from the simple grammatical standpoint of the passive voice. It appears that many of the social service cases presented could get a very considerable illumination from this source. Analysis of the individual in the light, say, of modern work on social psychology would demonstrate how every individual is, as it were, a group within himself, and how now one, now another, instinct would come to the fore.

Many of the skeleton social service histories were reviewed several times in the above and other connections. I will give one more instance of a scheme of analysis derived more from medicine than from sociology, but for all that, of some value. It can be objected that sociology too readily considers men as alike; too readily harbors such an idea as the Ricardian idea of the "economic man"; too readily entertains the thought that norms exist, and that the feebleminded and geniuses are merely low and high points on a smooth curve. Medicine at all events, though it endeavors to use the quantitative and statistical methods available, is more interested in qualitative differences, and may perhaps rather too readily find these in its material. Medicine looks more at what is lacking or has been lost, or is slanted and twisted out of shape, than at the low values of measurements. Medicine is one of those sciences that deal with evil as such. Sociology and ethics might very happily get on without much more evil than would serve as a condiment in a quantitative world. I uphold the possibly one-sided view that we should study evil in and for itself for the purpose of destroying it, or as much of it as possible, leaving the good and especially the millenniums and Utopias to take care of themselves. For this purpose, I made a tentative classification of the kingdom of evil as follows:

Disease
Ignorance
Vice
Crime
Poverty

Abstracting from other forms of evil, and so far as possible subsuming them under one of these five divisions, I inquired whether all the cases of social maladjustment did not relate with one or more of these great groups of evil. Whereas the tendency of the sociologist would be to consider poverty first as the arch cause of social maladjustment (the argument from the submerged tenth and the like), I felt that the first inquiry should be in all cases of social maladjustment, whether there was not somewhere in the situation a more or less *medical* scene. The figure in that scene might be an obviously sick, even a physically sick man; but, less obviously, the medical figure might be psychopathic, and the defect might be so mild from the medical point of view that no one really suspected that the nucleus of the social maladjustment was really a psychic one.

But again, supposing all question of physical or mental disease or defect could be ruled out, might not the dominant feature in the scene be some form of error, due to lack of education and intellectual training? It is really a positive evil in certain circumstances not to know the mother tongue of the country in which one lives. But again supposing there is no bodily or mental disease and nothing attributable to poor education, there might be, thirdly, some vice or bad habit due to poor moral training or demoralizing experience. All these, and the fourth question of being in some difficulty on account of the breaking of a law or ordinance, or being in the hands of some financial stress or debt, or other engagement, would need to be placed ahead, according to my view, in many cases, of any consideration of poverty as a cause of the social maladjustment.

In brief, before deciding that a case of social maladjustment is one of poverty and resourcelessness to be solved by the familiar methods of poor relief, it appears to me desirable to consider the maladjustment in the light of several prior hypotheses, namely, the hypotheses of disease, ignorance, vice (including bad habits), and crime or delinquency. This classification of existent evils and this particular order of examining them, I used in analyzing sundry social service cases from the Psychopathic Hospital. I found, of course, that many instances yielded evils of maladjustment in every one of the five compartments, but in almost every case there was no practical doubt which of the five compartments was the most important. But whether or no these groups of evil are the final ones, whether there should be more or less, and whether the order of consideration should be altogether altered, must remain doubtful. It seems to me that in any event some simple classification of maladjustments which can be borne in mind in rapid every-day work, ought to be set up, and that experience will determine in what order the analysis of social maladjustment shall take place. Just what fraction of the world's social maladjustments can be safely assigned to mental disease and defect, no man can now say.

In Miss Richmond's valuable book on social diagnosis, I found that fully half the cases there cited to illustrate all manner of general and technical contentions were cases with a strong psychopathic tinge; cases, in short, in which analysis would have found much to its purpose in compartment No. 1 of the kingdom of evil, namely, the disease compartment. If a collection of cases such as these of Miss Richmond's, chosen for quite another purpose, demonstrates so high a percentage of disease, and especially of mental disease, I think it is clear that a revamping of the whole attitude of social service to its problem may become necessary, and that social work in general will find itself far more medical than it ever formerly suspected; that medical social work will find itself far more psychiatric than any one had anticipated; and that psychiatric social work will find one of its chief aids in mental hygiene.

It would be possible to extend these "notes" greatly, and surely much must be said before the program of social psychiatry in its large outlines for social workers can be regarded as at all settled. Despite certain differences in point of view emphasized above between mental hygiene and social service, I feel that, in the war situation now confronting us, it is important for physicians and sociologists (or social workers, if the name please them more) to make common cause. I brought up the question at the outset, whether mental hygiene had the right to think of developing its own auxiliaries; that is, certain persons that might be called mental hygiene aides, who should stand to mental hygienists as public health nurses stand to the medical specialists in preventive medicine. I am inclined to think that, if such new class of mental hygiene aides were developed, the best source for them would be trained social workers. However, the trained social workers will probably be utilized quite to the full in various Red Cross and other fields. I think that teachers, librarians, psychological assistants, some specially selected nurses, and other persons having an equivalent training, particularly those having a collegiate degree, might be supposed to be the most promising candidates for such work. The chief argument for the A.B. degree is that it not only assures a certain maturity in years, but is rather apt to give the bearer some notion of the importance of language in any situation. Many of our problems are in persons without much English, and an appreciation of their difficulties is best had by persons who have had some sense of the difficulty of language learning.

I feel that a course for psychiatric social workers should be an advanced one, to follow after the lecture work in schools for social workers, though the undergraduate work in these schools also should contain a certain amount of mental hygiene. The advanced course should contain surely a résumé of applied sociology and of the technique of social investigation, and these lectures and corresponding quizzes should be made thorough and inclusive for persons without extensive training in social work. There should secondly, be a résumé of social psychology, using such a work as MacDougall's *Social Psychology* as collateral reading, besides various sociological works that nowadays give the psychological point of view an appropriate attention. Thirdly, the general principles of neuropsychiatry (considered as an entity compounded of clinical neurology and psychiatry) should be presented, preferably with demonstrations of patients, and with due remembrance of laymen's difficulties in nomenclature.

The threads of sociology, social psychiatry, and neuropsychiatry, should then be gathered perhaps in lectures on mental hygiene, on the general field of mental hygiene and on its applications to sociology and psychiatry. The relations of psychiatric social workers to physicians, nurses, occupation workers, vocation workers, and others engaged in reconstruction, should be particularly emphasized in this war-time course, and care should be taken that the work in physical therapy and in handicraft teaching and invalid occupation, should be sympathetically understood by the psychiatric social workers, even if such physical and occupational work is not to be undertaken by them.

Supposing such a course to occupy three to six months, it might be possible for some twenty social cases to be worked with by each student under supervision during the time of the course, provided that the course is given in a centre where such cases are available and under control. Every psychiatric social worker should be familiar enough with mental tests to understand their applicability, value, and limitations. Some twenty mental tests should be performed under supervision during the lecture course. Meantime, the insane, the psychopathic, and the neurotic groups of patients should be seen by the psychiatric social workers so that the legal and medical points of view may be understood.

The courses on social psychiatry for social workers which have occasioned my writing these reflections, were naturally far from complete and only remotely touched several of the major branches here mentioned. In endeavoring to delimit the subject of social psychiatry and lay down its main points for lay social workers, I concluded, however, that lectures for psychiatric social workers of value in the war would have to be at least as extensive and comprehensive as above sketched. That the majority of the war cases will be under military control of course both simplifies and complicates the social service problem, and the military point of view would probably need to be expounded in a separate division of the course.

SUMMARY

Some reflections have been put together on a course for social workers on social psychiatry recently given in Boston. These reflections deal largely with some distinctions between mental hygiene and social service. Mental hygiene is regarded as a branch of medicine, in a sense co-ordinate with the psychiatric branch of social work.

At first, the distinctions between mental hygiene and psychiatric social work are very clearly and definitely drawn. Particular emphasis is laid upon the individualism of the point of view of mental hygiene as against the groupism of social workers; but in the end, it is pointed out that if mental hygienists are to obtain auxiliaries, such as every expert eventually obtains in the evolution of his art, these mental hygiene aides will probably be best drawn from the ranks of the social workers; they will be a kind of specialized and advanced social worker.

The point is that as the mental hygienist advances from the individual to the family and thence to the community, so the social worker, at first aiming at the community, focalizes upon the family, and finally gets a point of view concerning the individual not far from that entertained by the mental hygienist.

Despite the logical differences, then, between the point of view of mental hygiene and that of social work (logical differences which it is well to bring out when endeavoring to get the medical point of view to some extent over into the minds of the social workers), there will be in practice little doubt that mental hygienists will find some of their most valuable aides in specially trained social workers. Just as the orthopedists will use nurses and others skilled in physical therapy, and just as the vocation workers will use persons specially trained in invalid occupation and in handicraft teaching, so the mental hygienists in war time will crave the aid of specially trained social service auxiliaries; that is, mental hygiene aides that have been given special training.

In the Boston course, largely for advanced social workers who had all had a pretty definite curriculum, stress was laid upon sundry methods of analysis of social data after their collection. Among these methods of analysis was one which took up the question of the public, social, and personal aspects of whatever problem of maladjustment was in question. Another dealt with the analysis of the patient's subjective attitude to his environment and himself—a question of the passive voice. A third dealt with a method of analyzing data from the standpoint of the evils found in evidence, and for the purpose of orderly analysis, a tentative rough classification of the kingdom of evil was given.

In view of war contingencies, brief suggestions have been made as to the desirable content of courses for psychiatric social workers of value in war time and after.

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MENTAL DISEASE IN THE FIELD

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DURING a year's service as Regimental Medical Officer with the British Expeditionary Force in France, I had an opportunity to see a fairly large number of mental and nervous cases; and although, unlike physicians serving in base hospitals, I had no opportunity to make a careful study of my cases, I found some compensation in the fact that, serving in the line, I had a better opportunity to observe the conditions under which they developed and the practical problems which they presented to the military organization. I should like to review the principal types of cases that came under my observation and the causes to which they appeared to be due.

The cases to be considered may be conveniently divided into three groups:

1. Mental and nervous ailments existing at the time when the men suffering from them were passed as fit for service.
2. Cases of maladjustment to routine army life.
3. Mental disorders brought on by the strain of actual warfare.

Amongst the cases of mental and nervous disease passed as fit for service, there are some that any physician should be able to detect. For example, I found in a battery in France a case of cerebral syphilis with hemiplegia, which hemiplegia the history showed to have existed at the time when the man was passed as fit for service. Again, there are cases that get into the army which could be eliminated if recruits were subjected to a mental examination by capable psychiatrists. In this class fall many cases of mental defect and early dementia praecox. It would probably not be worth while to make a routine mental examination of every recruit; but whenever, in the course of the ordinary medical examination, the examiner has occasion to suspect the existence of mental disease, it should be possible for him to refer the recruit to a psychiatrist in order that a thorough mental examination might be made. By this means, without necessitating any great amount of work, cases could be eliminated which otherwise impose a considerable burden upon the military organization. For example, one mental defective who in civil life was a fairly efficient farm laborer, and who was therefore in the present emergency to be rated as an asset to the nation, was drafted into the army, where he proved to be absolutely useless. A brief mental examination would have demonstrated this man's unfitness for military duty. As it was, by taking him from the farm, the country lost not merely the value of his services there, but also the not inconsiderable sum spent in equipping and maintaining him in the field. More than that, by reason of the dullness he displayed in learning the drill and in all his work, he delayed the training and lowered the efficiency of the entire unit to which he belonged.

But although some cases of mental and nervous disease can be eliminated in the course of a formal examination, there are many others which cannot. For example, there are those cases of epilepsy which present neither physical nor mental indications by which the condition can be detected. Speaking from my own experience, I should say that epilepsy is a very common form of nervous disorder in the British army; and its prevalence would seem to be due in part at least to this difficulty in detecting it. Unless the recruit should happen to have a seizure during the examination, one is obliged to depend solely upon the history given, and this is apt to be of very little value. If the recruit desires to be passed for service, he commonly conceals the fact that he has had seizures; while on the other hand, if he is a slacker desirous to avoid the performance of military duty, his statement that he is subject to fits may be quite false. Neither are the statements of his friends to be depended upon, for they may be conniving with him. Even physicians, in the present war, have been guilty of making it their business to assist recruits to obtain exemption on medical grounds. In view of these facts, unless there is good evidence to show that a man is a genuine case of epilepsy, the examiner very properly gives the army the benefit of the doubt, and, if the man is otherwise sound, passes him as fit for service. The result is that a good many epileptics are passed into the army and have to be weeded out later.

The second group of cases consists of men who do not necessarily become insane, men who, owing to constitutional or acquired defect, are unable to adapt themselves to routine army life, and therefore cannot be made into good soldiers. The following is an example of this kind of case.

The man was an eccentric individual, intensely religious, obstinate, and of poor judgment. As a stretcher bearer he had shown unusual courage. Supported by the firm belief that God was always with him, guiding and protecting him, he had carried in the wounded under very heavy shell fire, showing no concern whatever in regard to his own danger. The strong religious faith and fixity of purpose here displayed would have been very valuable fighting qualities if they had been made use of only when in conflict with the enemies of his country. But the trouble was that this man showed the same reaction in his conflicts with the non-commissioned officers over him, being led into these conflicts by his lack of judgment and very peculiar religious beliefs. The result was that, not being amenable to discipline, he was useless as a soldier.

Such a man as this could not be classified as insane; and yet he was quite as useless and quite as much a burden on the military organization as if his abnormal tendencies had resulted in the development of some recognized type of mental disease.

There are, however, cases of maladjustment that do become insane. In such cases, we may assume that the man's mind is in a state of more or less unstable equilibrium, and that, when he finds himself in an environment to which he cannot adjust himself, the resulting disharmony existing between him and his environment so acts upon his mind as to upset its balance and bring about a psychosis. Such a case was that of a young man, sensitive, seclusive, and accustomed to a sheltered environment in which he had been able to keep very much to himself. On joining the army, he found himself compelled to eat, sleep, and spend all of his time in intimate contact with a body of men who for the most part were uneducated, rough and boisterous. Often this intimate contact with one's fellows serves to break down seclusive tendencies. In the present case, it served only to intensify them. The young recruit could not bring himself to mingle with his uncongenial companions; and being obliged to live among them although not of them, his position was a very uncomfortable one. It is easy to see how, being so situated, he became very self-conscious. He felt whenever the men laughed that it must be at him. He grew to believe that he was disliked. In this uncongenial environment he sank into a depressed condition, grew dull and sluggish. Thus it came about that he did not display the necessary degree of smartness on the parade ground and in his work. His sluggishness caused him to be singled out for repeated reprimands from the drill instructors, and as a result he came to feel that the officers also were against him. So he grew more depressed and his ideas of reference more pronounced, until he was finally evacuated from his battalion as insane.

In these two cases, we see two types of maladjustment to the demands of army life. In the first, it was a failure to adjust to the disciplinary demand, the demand for obedience. To this demand the man responded with insubordinate conduct that made him useless as a soldier. In the second case, it was a failure to adjust to the social demand, the demand for that spirit of comradeship which cements together a body of men into an efficient unit. The recruit responded to this demand by drawing more into himself. The disharmony between himself and his comrades resulting from this type of conduct reacted upon him to disturb his unstable mental balance and to precipitate a psychosis.

In the army at the present time one meets a good many unadaptable individuals. In time of peace these men tend to escape attention. They are taken care of by relatives; they find some kind of niche in which they are able to earn a livelihood and get along after a fashion; or, not fitting in anywhere, they drift about, here today, there tomorrow, without receiving much attention from anyone. When, however, as at present, the manhood of the nation is called to the colors, these men are drawn in with the others; they are given a place in the military organization; and then a realization of their unfitness is forced upon us. What are we going to do about them? We might make an attempt to prevent them from entering the army, but such individuals are not easy to detect by means of a formal examination. More than that, men of low grades of intelligence, ill-balanced, even criminal types, men who seem unadaptable in civil life, often make excellent soldiers. To attempt to weed out all such individuals, therefore, is to deprive the army of some excellent fighting material, as well as to keep at home a class of men that the nation can very well spare. It is on meeting cases of this type that one is impressed with the absurdity of war, to which the nation sacrifices its strongest and best, while keeping at home the weaklings and the unfit to perpetuate the race. The only course possible with these ill-balanced individuals is to allow them to enter the service, and then to weed out in the training camps those who subsequently prove useless. However, in order to prevent such cases proving a needlessly heavy burden on the military organization, medical officers should be educated in regard to them, so that they may be recognized early and disposed of without unnecessary delay.

In the group of cases resulting from war strain, the important exciting cause is found in the action upon the fear mechanism of the horrors and dangers of the battle front, of these shell fire being the most important. When a man is first sent up to the front, he generally is very much alarmed by the roar of the shells passing overhead. In a little while, however, he becomes accustomed to this. He discovers that his life is not seriously threatened every time a shell is heard; and so, as time goes on, shell fire troubles him less and less. Sometimes, however, we find the reverse of this. We find sometimes that a man (he may be a raw recruit or a seasoned veteran) gradually "loses his nerve." Shell fire which previously troubled him but little, now begins to worry him; he grows more and more apprehensive, until he may become quite unfit for service in the line and have to be evacuated. The following is an example of this type of case.

The patient was an artillery officer who for several weeks had worked unusually hard, and had been repeatedly exposed to severe shell fire. Under this strain he gradually became more and more nervous; and when I examined him, he had become so exceedingly apprehensive of shell fire that he was no longer able to control his fear. The shelling kept him awake at night. He was tremulous, complained of headache, and was no longer able to "carry on." It was therefore necessary to evacuate him.

A condition similar to the one just described may, however, instead of coming on gradually, be produced quite suddenly as a result of some particularly trying experience. For example, a man who never has been regarded as at all nervous some day has a shell burst very close to him. He is half buried by it, and perhaps his comrades are killed before his eyes. After this he can no longer control his terror of shell fire. He cannot sleep at night, and comes up to sick parade shaking from head to foot, probably much ashamed of his nervousness, but quite unable to control it. The following will serve as an illustration of this type of case.

The patient was a cool and efficient young officer, but within a single week he was exposed to three severe nervous shocks, which proved too much even for his apparently good powers of resistance. On the first occasion a shell burst close beside him, knocking him flat on the ground and covering him with mud, but not wounding him. A couple of days later a shell burst on the edge of a trench in which he was standing, almost completely burying him. As far as could be seen as the time, neither of these shocks had any serious effect upon him. But the third experience followed only a couple of nights after the second. As far as can be learned, he was alone in an advanced position when a shell burst near him, flinging him to the ground. He must have picked himself up after this and found his way back to his billet, although he had no recollection of doing so. When I saw him the next morning, he showed no physical injury beyond a slight bruise on the forehead, probably caused by a lump of earth striking him. He was still slightly confused and complained of headache. He trembled violently, and the sound of shelling drove him almost into a panic. He was evacuated as a case of shell shock, and according to information received later, was not likely to be again fit for active service for a long time at least.*

In the cases just described, the condition seems to be the direct outcome of a stimulation of the fear mechanism through exposing the individual to one or more emotional shocks of greater or less severity. But all men at the front are subjected in a greater or less degree to emotional shocks. All are exposed to danger. What are the factors, aside from the severity of the shock, that determine which individual shall react with a psychosis and which shall remain unaffected?

The personality, the constitutional make-up of the individual, is certainly the first factor, one man being much more easily and profoundly affected by the dangers and horrors of war than another. The importance of this factor is so obvious and so generally recognized that it is unnecessary to enlarge upon it.

A second factor is fatigue, exhaustion, a condition of ill health. The physical strain upon the men at the front may be very severe, even when there is no heavy fighting in progress. Take, for example, a man who in peace time has led a sedentary life, his days spent behind a desk, his evenings by a warm fireside. He is drafted into the army, and after a few months' training is sent to join a battery in France. Here he works all day in the mud and snow, digging gun positions, carrying heavy shells; and in the evening retires, not in dry clothes to a warm bed, but to a dilapidated barn, where he wraps his blankets about him over his wet uniform and lies down on the floor to get as much sleep as his state of physical discomfort will allow. During an offensive, when the men may be obliged to work all day firing their guns and work all night shifting them to new positions, the physical strain is even more severe. With the lowered vitality resulting from such conditions, there is more nervous trouble, as well as more illness of every other kind. This of course is only to be expected. It is generally recognized in civil life that a person in poor health is more profoundly affected by any emotional shock than one in a normal condition. When we are tired or ill, little things worry and upset us which when we are in robust health do not trouble us at all. It is therefore to be expected that men who are in a poor physical condition should react more strongly to the emotional shocks of war than men in robust health. Along with the purely physical fatigue we must also bear in mind the nervous fatigue that comes from worry and anxiety. This of course comes mainly to the officers, upon whose shoulders all the responsibility for the work rests. It is no doubt owing to this fact that during an offensive the officers complain more of "nervousness" than do the men.

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*In reports from the hospitals of cases of shell shock, aphonia, monoplegia, and various other hysterical manifestations figure prominently. In the cases which came under my observation at the front, these hysterical symptoms were not present. I have talked with other medical officers similarly situated to myself, and their experience has been the same as mine. Of course, a Regimental Medical Officer sees at best only a small number of cases, and it would be unsafe to draw inferences from the experience of only a few men. Nevertheless, it seems not improbable that these hysterical symptoms are of late development. The patient has a monoplegia or aphonia only because he thinks he has, and as a rule he is well back from the front and on his way to the hospital before he has an opportunity to think of such a possibility. Hence, these symptoms are as a rule seen only behind the lines.

A third factor is the depression resulting from the monotony and discomfort of life at the front. Imagine a winter in France, spent as many of the men spend it, living in a hole underground, dark, narrow, unventilated, and often dripping with moisture, an abode compared with which the average coal cellar is both luxurious and cheerful. When a man leaves this, his home, it is merely to go out and wade in an expanse of mud, trenches full of mud, fields of mud, roads of mud; to engage in the most dreary, uninteresting round of duties, digging trenches or carrying up shells, while his wet clothing sticks to his chilled body. Subjected to this dreariness and discomfort, is it any wonder that some of the men become depressed, "fed up," that they come to care nothing about the war except how they shall escape from it?

I have seen a depression of the manic-depressive type result apparently from this cause and this alone, although such reaction is probably rather rare. Nevertheless the depression which all feel to a greater or less degree, although it seldom attains the severity of a definite psychosis, constitutes a condition of mental ill-health which is important for two reasons. In the first place, it means a general loss of morale, a lowering of the efficiency of the troops; and in the second place, it causes the soldier to react more readily to the horrors and dangers to which he is exposed. If a man's martial ardor is high, if his heart is in the fight, then his danger is as nothing to him; his mind is not upon himself; he feels no fear, and the shells falling about him affect him not at all. Take, however, the same man. Let him become depressed in spirit. Let him lose heart in the struggle. His thoughts now turn to himself and his unfortunate position. His chief concern is for his own personal safety. The result is that the falling shells, formerly regarded with indifference, now give rise to intense fear, and become capable of producing that condition of mind underlying what we call shell shock.

But these factors in the production of the war psychoses are complicated by another factor, a factor which has its root in the patient's own mind. This is the wish to be ill. Living under conditions that are at once dangerous, uncomfortable and monotonous, the men, as already pointed out, are apt to lose all martial ardor, to become utterly sick of the war, their only wish being to find some way of escaping from it. The soldier, in this state of mind, begins to hope for some illness, some wound not too severe, that will take him out of the line back into a safe, comfortable hospital, or, better still, all the way back to "Blighty." The first question the British Tommy is likely to ask when brought in wounded is, "Is it a Blighty touch, Doctor?" For this reason threatening ailments are hopefully watched and cultivated. I have more than once known a man to hold back from attendance at sick parade, hoping that his ailment, if left untreated, might become so serious as to necessitate his being sent to hospital. As a result of this mental attitude one finds all grades of malingering, from the shameless liar who presents himself at sick parade with a list of purely fictitious symptoms, up through the individual who really suffers from some slight ailment and like a good lawyer makes the most of his case, to the man who has really succeeded in making himself believe in the seriousness of his condition, who has succeeded in developing a malady which, in the language of the psycho-analyst, is a "wish fulfilment." This wish to be ill we naturally find operating in our shell-shock cases. They are men who have had a rough time in the line, and the dread of returning to it always hangs over them. If they get better they will be sent back to fight, so some take good care not to get better.

In conclusion, I might call attention to the fact that in the cases resulting from war strain there is little if anything that is really new. Emotional shock, fatigue, etc., the various etiological factors which give rise to war psychoses, are all found operating in civil life; and as for the psychoses themselves,there is probably nothing in their symptomatology that cannot be duplicated in the ordinary psychiatric clinic of any large city. The difference between peace conditions and war conditions and the mental disturbances resulting from each, is not a qualitative difference, but a quantitative one. Under peace conditions, for example, men are subjected to emotional shocks in no way essentially different from those produced by shell fire. But under peace conditions these shocks are of rather rare occurrence, and as a rule so mild as to affect only those who are mentally unstable. Under war conditions, however, they are of constant occurrence, and frequently so severe as to affect the strongest and best balanced of men. Thus etiological factors and types of mental disorder to which formerly we gave little attention have, with the altered conditions produced by the war, suddenly thrust themselves upon our attention; and as a result there has been a tendency to treat of them as if they were something altogether new.

COMMUNITY RESPONSIBILITIES IN THE TREATMENT OF MENTAL DISORDERS*

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IN the early period of community organization in this country mental disorders were nowhere so well understood or so intelligently treated as they are now. Two conditions, however, which are frequent consequences of mental disorder early compelled attention; namely, disorders of behavior and dependency. At first the only organized provision made for persons suffering from these disorders had reference to these two conditions. It was the duty of the constable and the poor-master to protect the community from the acts of disorderly persons, and to extend to the dependent the organized aid which the community felt it necessary to furnish. For the disorderly insane person the lock-up served the same purpose as it did for the disorderly sane person, and for the dependent insane or feebleminded who were not disorderly the almshouse furnished food, shelter, and attention as it did to all other dependents. Little attempt was made, in those days, to inquire into the causes and conditions which occasioned behavior disorders or dependency or to provide for the special needs of individual cases.

As the communities grew in population and advanced in knowledge, however, the problems which arose in connection with this simple method of disposing of persons who were mentally disordered grew more complex and difficult, and the number and gravity of the cases in which the inadequacy of the method was exposed excited more interest and comment. To meet this situation, it became necessary to make a distinction between the disorderly sane and the disorderly insane, and departments in which the latter could be given separate care were established at the almshouses. The narrow barred cells, the heavy doors with peep holes, and the restraint apparatus which marked this development are still to be seen at many almshouses from which the insane have been long since removed. The constable and the lock-up were still utilized, but an effort was made to restrict their services to temporary needs. We have not yet completely emerged from this period in the care of the insane. In many communities throughout the country, probably in most, the only organized agencies for dealing with mental disorders are those which have to do with disorderly behavior and dependency, regardless of the cause. In fact it has been truly said that in the organized methods by which insane persons are still dealt with in this country examples can be found of every form of neglect and abuse to which the insane have been subjected during the past two hundred years. The surveys made by the National Committee for Mental Hygiene have furnished considerable evidence of this. To anyone who may be sceptical I would suggest the reading of an article entitled "The Insane in a County Poor Farm" by Dr. Thomas W. Salmon, which appeared in MENTAL HYGIENE in January, 1917. This is a true account of the provision which is made now for the care of insane persons by a prosperous community in this country.

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* Read before the Connecticut State Conference of Charities and Corrections, April, 1918.

Notwithstanding these residuals of a former period, however, great advances have been made in the care of the insane. The medical needs of the cases have always been recognized by some, and physicians and philanthropists have from a very early period of the nation's development been engaged in efforts to provide for them. Many of the almshouse annexes were gradually developed into separate departments or separate institutions under medical management. Private funds were applied to the establishment of high-grade institutions where the best standards could prevail, and some of the earliest institutions for the treatment of mental disorders in this country were of this type. Eventually the legislatures in one state after another took up the question of the needs of the insane, and now in every state may be found state hospitals, medical institutions in which provision is made for treatment and attention which will promote cure. At first these institutions were looked upon merely as asylums where the insane could find refuge from the ignorance and indifference which had previously characterized their treatment. With the general advance of medical and nursing knowledge and standards, and the further enlightenment of the public, it has become possible to elaborate them into truly curative agencies. Unfortunately, there are still many states in which the provision made by the State is inadequate for the total number which require it, and many are still cared for in the almshouses.

In several of the states, the number of which is steadily increasing, the whole burden of providing institutional care and treatment for the insane has been assumed by the state government. Wherever this has occurred, the result has been a better level of intelligence and humanity in dealing with the cases under institutional care. State care is properly regarded, therefore, as a goal to be reached in the progress towards an efficient public system for dealing with mental disorders. It accomplishes much more than the mere transfer to the state of the responsibility of providing institutional care. It raises the prevalence of mental disorders with their causes, prevention, and management into the dimensions of a state problem of the first class. And, while, after state care has been adopted, the first task to be accomplished is to bring all cases which require institutional treatment into state hospitals, it is soon found that this by no means accomplishes all that is required for dealing adequately with the needs. Unless the vital issues occasioned by mental disorders in the homes, the schools, the industries, and in social relations are intelligently grasped and dealt with by means of the state system, state institutions are liable to be looked upon as a resource which is only to be appealed to when complete separation of the patient from his usual environment has become imperative. They will still be regarded as asylums. In such case, their development is likely to be in the direction of great custodial centres, and economic and so-called business considerations in their management are likely to prevail over those dictated by science and humanity. This has happened in more than one state in which state care has been adopted under conditions of great promise. A system of state care must, to be effective, not only be adopted, but it must be planned and developed with reference to the known needs of the sufferers from mental disorder. A well-defined policy is essential and carefully prepared plans. The best plan is probably to divide the state into districts containing not more than 500,000 inhabitants each, and to provide a state hospital for each district. This hospital should be so conducted as to serve to the fullest extent possible the needs of the district in dealing with mental disorders. With this in view, the necessity of educating the public to a proper understanding of the purpose and advantage of the institution should be considered. Unless steps are taken to this end, the process of substituting for the prevailing views and methods the newer conceptions and resources will require a generation.

This necessity is all too frequently lost sight of and progress is thereby greatly retarded. The state hospital is to be regarded as a social welfare agency and a centre of information and useful service which can be confidently appealed to in dealing with the problem of mental disorders in the district which it serves. In states in which a state system of care of the insane has been most fully developed the lines of progress have been towards the application of this view. Developments have been made for the purpose of bringing the district hospital into more intimate relation with the needs of the various communities in the district. In some states nurses from the state hospital, and sometimes a physician, are sent to the communities to bring the patients to the hospitals. Out-patient departments are conducted in various parts of the district where persons who wish advice concerning mental disorders may apply. Social workers are employed to visit, at their homes, patients who have been discharged from the hospital or who may have applied at an out-patient department. These contacts with the communities have an educational value and furnish means by which the hospital may contribute to the management of the problem of mental disorders as they occur in the home, in the school and in the commercial, industrial and social life of the people. Instructive literature relating to the nature, causes, and treatment of mental disorders, and to the utilization of the resources of the hospital is widely distributed. The physicians of the hospital aim to inform the medical practitioners of the district and the public, by means of scientific papers and addresses, concerning the conditions met with in patients and the purposes and plans of the hospital. By these methods, a state hospital becomes an aggressive agency for dealing with mental disorders throughout its district.

The usefulness of a state hospital to the various communities of the district which it serves is, to a considerable extent, dependent upon its proximity and accessibility. When a district contains several counties, as is usually the case, the largest number of admissions in proportion to population is usually from the county in which the hospital is located, and the proportion diminishes with distance and inaccessibility. It is thus possible to obtain statistics that seem to show that proximity to a hospital for mental disorders increases the prevalence of insanity. What is really shown is that ease of access, and possibly correct information concerning a state hospital, are conditions which are necessary to its highest usefulness. The proportion of cases in the more distant or less accessible counties of a district is not likely to differ to any great extent from that in the counties nearest the hospital. Unless, therefore, some other means for obtaining hospital treatment are available for the latter, many cases for whom such treatment is indicated must fail to receive it.

The extent to which a state hospital can be utilized, even by the community in which it is located, is also limited by the conditions under which patients may be admitted. Certain legal definitions and formalities prevail in determining the cases to be admitted to a state hospital. The patients must be insane within the meaning of the law. This indicates that cases for admission must be differentiated and selected from a larger group of cases of mental disorder existing in the community. The best system of state care which has yet been established does not undertake to provide hospital treatment for all types and grades of mental disease. The acute deliriums of fevers and intoxications, and the large groups of cases which are designated by the terms neurasthenia, hysteria, and psychasthenia, and several other forms of mental disorder, are, with the exception of a few of the cases in which the symptoms are unusually severe, not ordinarily included in the types for which hospital treatment is provided by the state. There must necessarily also, in all cases of mental disorder, be a period in which observations must be made, diagnoses determined, and arrangements made for admission to a state hospital when this is found to be necessary. This may be a very critical period in the course of the illness, and as first aid applied to an injury may determine the final outcome, so the early treatment furnished a case of mental disorder may be of the greatest importance in determining the further course and outcome. The first treatment of a case of mental disorder, as of any other form of disease, must ordinarily be given wherever the patient may happen to be when the need becomes manifest. In many instances the condition is only recognized when immediate treatment has become imperative. It seems quite unlikely that any state system will be inclusive or elaborate enough to provide for all grades and forms of mental disease which require hospital treatment. Needs will still remain which will require that some organized provision be made by each division of the state and each community.

The best test of any system of providing for the treatment of persons suffering from disease is to examine its operation in a number of cases. A few years ago a study of this kind was made in one of the states for the purpose of ascertaining the methods and provision employed in the treatment of persons suffering from mental disorder previous to their admission to the state hospitals. This study covered the admissions during a period of two years. It was made easily possible because of the practice of sending nurses to bring the patients from the communities to the state hospitals, which has been in operation in the state referred to since the state-care act was adopted many years ago. These nurses were asked to make reports concerning the condition and environment in which they found each patient. The system of care in this state is considered to be as good as any in the country if not the best. The law under which it was established defined the types of cases which could be admitted to the state hospitals and the conditions of their admission. It was left to the local authorities, however, and to relatives and private physicians to provide the means for observation, first diagnosis and determination of the need of hospital care, and for temporary treatment. The study which was made revealed that, throughout the state, little advance had been made in the local provision and methods since the period when the behavior disorder and dependency of an insane person were the only issues that received organized attention. The poor-law authorities and the police were still the only officials who were required by law to see that an insane person received attention. It was found that in only one county in the state outside of that in which the largest city is located was there any organized provision made for temporary hospital-care and skilled observation or nursing. In the largest city provision for the termporary hospital treatment of mental cases was furnished at two general hospitals. More than half of the patients received at these hospitals were, however, brought in by the police. In the portion of the state outside this county, seventy-five per cent of the patients admitted to the state hospitals in the first year covered by the study were brought directly from their homes, and it was found that, of these, fifteen per cent or 410 persons during the first year covered by the study, had suffered from gross neglect or unintelligent harsh treatment. Some of these instances are as follows: (1) A woman was brought from her home where she had been in a disturbed state. She had been held in bed by a network of ropes, her ankles bound together, her knee strapped and mittens on her hands. The patient died a few hours after admission and an autopsy disclosed a rupture of the stomach. (2) A woman was found at home where she was fastened to a chair by a sheet tied about her and nailed to the wall. She was confined in the room with her husband who was dying of pneumonia. The chair in which she sat was nailed to the floor. The doors of the room were nailed up at night. She was dressed in an undervest and men's trousers, and had been bound hand and foot in bed for a few days before she was transferred to the hospital. Many other instances could be cited. More than seventeen per cent of the patients, or 466 persons, received during the same period at the state hospitals from this portion of the state were found in jails, lockups and police stations. Eighty-seven of these patients were women. The reasons for confining the patients in these places were not always apparent from the reports. In some instances they were said to have been violent or otherwise dangerous, but others appeared to have merely been wanderers, or to have shown eccentric behavior or expressed delusions in public. Many of these patients were found in unsanitary, uncomfortable, sometimes filthy and vermin-infested cells, not infrequently in company with persons accused of crime. In one instance the patient was found in the same room with a person accused of murder and developed a delusion that she herself was accused of the crime. In another, a woman was found in a basement cell, without windows, with no toilet facilities, and separated only by a slat door from the quarters of a drunken man. The patients sometimes received what care was given from prisoners, or they were found in a common room with drunkards and tramps. In a jail in one of the larger cities of the state, a woman was found by the nurse in a cell which was so small that she could scarcely sit up in it. There were no toilet facilities accessible to her and she was entirely naked and extremely filthy and dirty. In a police station two male patients were found confined in a box-like structure with board sides and an iron grated top, hinged and fastened with two locks. When the top was closed, the patient could not rise from the recumbent position, and, as he lay there, the distance between his chest and the bars of the top was only six inches. Another patient was found in a cell which was not heated though the weather was cold. He was insufficiently clad and was so ill that he died two days after admission to the hospital. In a large number of instances, the report states, women were confined in station houses and lockups without attendance by persons of their own sex. One insane woman was entirely nude in a cell and there was no one to wait on her except a man who brought her food to her.

To appreciate the significance of these methods of dealing with persons suffering from mental disorders, it is necessary to keep clearly in mind that they were found to prevail throughout one of the most progressive of the states in the care of the insane, in which an excellent system of state care had been in operation for nearly twenty years. This system was, however, devoted practically altogether to furnishing institutional care to persons who were delivered over to it by the communities. Nurses from the state hospitals were sent to bring the patients in, but there the active concern of the state system ended, and those who were interested in its development paid little or no attention to what was happening to the cases outside the hospitals. The inferior methods still employed by the communities were the outcome of the persistence of views and methods which regarded the dependency and behavior disorder of an insane person as the main issues. It was seen, therefore, that the first step towards improving the methods should be to place the responsibility for the care of the cases in the hands of some official who would be more likely to consider the medical needs of the cases the main issue. To this end, the duties of providing for insane persons were transferred by statute from the poor-law authorities to the medical health officers and the confinement of the cases in jails and lockups was forbidden. Since this change was made, the methods have been greatly improved, though the prevailing ignorance and low standards concerning mental disorders, even in the medical profession, hinder the development of the organization and facilities which are needed. Special knowledge, special skill, and in many instances special facilities must be available for the proper understanding and treatment of mental disorders. These are not yet demanded by the intelligence and interest in the subject that prevail in any community. They can be secured only through the efforts of a few specially informed and interested individuals. They would, however, I am sure be acceptable to the community, and willingly paid for as soon as their purpose and value were understood.

In every large centre of population a department for nervous and mental cases should be provided in connection with the best general hospital. This department should be so organized and equipped that the patients would be treated by the most approved methods at the hands of specially trained and experienced nurses and physicians. In no class of case is the necessity for specialists more pressing. In fact special knowledge and skill are the only sure safeguards against gross neglect and mismanagement in the treatment of mental cases. The department should be open not only to the patients of the city in which it is located, but to those of the more easily accessible smaller communities where there are no hospitals. These communities would, through their health officers and the more enlightened citizens, probably have to be educated to bear the expense of the transfer and treatment of the patients. A comparatively few of the cases would, however, require hospital treatment until they could be sent to the state hospitals. Most of them could be cared for at home, with attention, in some instances, from a specially qualified nurse who ought to be obtainable from the hospital. It is discreditable to the intelligence and humanity of any community when no better provision for a delirious or frenzied sick person is made than the police station or lockup, and when no more skilled nor tender attention can be supplied than those of the constable and the poor-master.

The communities might also use to greater advantage the resources of the state hospitals. This is especially the case in those places nearest to the hospitals. Access to these resources should be as easy as possible, and means should be taken to inform the public concerning the methods and advantages. The hospital of a district is a centre of information and assistance in all matters relating to mental disorders. The communities should learn to utilize them fully, and the state system should provide for state supervision and standardization of local provision and methods. A system of co-operation may thus be established which will make it possible to secure good treatment for a patient during the whole period of illness.

The problem of mental disorders as now understood is no longer properly formulated by the phrase "the care of the insane." Mental disorders of many forms and in many stages are extremely prevalent. Those regarded as insane are simply the cases whose capacity for adjustment to the requirements of organized society has failed to such degree that they have become a burden or a menace. The problem of early treatment and of prevention can never be solved merely by the care of the insane.

Each community must take it up for itself and provide such organized attention as is given to any other social problem, for example, education, sanitation, transportation, etc. This view is already beginning to find practical application in the schools, in the courts, in the prisons, in the army and navy, and wherever departures from normal behavior require attention. It is of vital interest to all of us that the means provided for dealing with mental disorders in the community should be adequate. No one is immune from these disorders, and when a case occurs in a household in a community the situation is one which demands very special knowledge, skill, and facilities.

Permit me, then, in closing to suggest for your careful thought and investigation as you take up again your contacts and interests in your own communities the following questions:

1. If a case of mental disorder should occur in your household what would you do?

2. How and where would you obtain skillful medical and nursing attention?

3. If the patient were delirious, frenzied, or uncontrollable as is sometimes the case, how and where would you find near at hand a suitable place where he could be safely and properly treated?

4. To what extent is the state hospital of your district used by your community? Could its usefulness be increased?

5. If you find that the means provided for dealing with mental disorders in your community are inadequate can you not do something to improve them?

THE ORGANIZATION OF A STATE HOSPITAL FOR MENTAL DISEASE*

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THE demands of the army for physicians, nurses and attendants trained in psychiatric work have resulted in a serious condition of shortage in the supply of such persons for civil service. Under these circumstances it becomes more than ever necessary to organize the state hospital for operation at the highest efficiency in order, as far as possible, to offset the deficiency in trained help.

Fortunately, the increase in the number of committable cases of insanity resulting from war conditions has so far proved to be very small, and experience abroad does not justify any expectation of large numbers of cases of this kind. The main increase in mental disturbances concerns psychoneurotic and borderline conditions the care of which will take place largely outside the state hospitals which must, however, be prepared to assist largely in this work. I have been asked to confine my remarks to conditions within the hospital and therefore shall touch only incidentally upon this feature, although I am fully cognizant of its great importance.

In discussing the question of organization it is necessary first to consider the functions which the state hospital is called upon to perform and the results desired. For a long time such institutions were regarded as purely lodging houses for the segregation of those who, by reason of mental disorder, were unfit for ordinary social life. Gradually this gave way to the so-called "hospital idea," by which was meant an approximation of methods and equipment to those of a hospital for physical disease. While this represented a decided step forward it has nevertheless, in my opinion, been to some extent a failure for the reason that it has not taken sufficiently into consideration the very special character of the work to be done and the fact that many of the inmates will inevitably remain permanently within the institution although not "sick" in the ordinary sense of the word at all.

The recognition of the existence of mental disorder necessitating care in a state hospital does not have the same significance as the diagnosis of bodily disease requiring treatment in an ordinary hospital. Disease may, it is true, be present, but the principle fact is disorder of behavior and in the majority of cases no evidence of disease in the ordinary sense is to be detected. The hospital for the insane must, therefore, be organized primarily with the object of treating behavior, the ordinary practice of medicine being, though essential, a less important branch of its activities. Only when this is fully grasped and adequately provided for shall we be able to achieve even an approximation to the ideal hospital for mental disorders.

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*Read before the mental hygiene section of the National Conference of Social Work, Kansas City, May 15–22, 1918.

Behavior is in part the result of inherited nerve connections, but to a much greater degree it is the outcome of education and training. A state hospital must, therefore, be planned primarily as an educational institution. Its efforts must be directed toward the correction of faulty habits and the establishment of new ones designed to enable the individual to behave in a manner compatible with social life. Even when full correction is not secured, as unfortunately must frequently be the case either because the faulty habits have become too deeply ingrained before the individual comes under treatment or for some other reason, partial success may be accomplished and the patient become capable of living more or less satisfactorily in a modified or simplified environment such as in that of the custodial division of an institution or under supervision outside.

The education required does not differ in principle from that which is given to the child. We cannot hope, even if it were desirable, to remove feelings, desires and passions which are inherent in life itself. Our efforts, therefore, must be directed towards providing means compatible with social existence for the outlet of the energy which these emotions represent. This implies occupation endowed with interest, exactly that which we try to develop in children even though we perhaps do not plan our educational system with this consciously in mind. It must also be the corner stone of state hospital organization.

In planning the organization this central feature must be kept continuously in mind if we are to develop any purposeful and orderly system. In the past many of the arrangements have developed more or less in a haphazard way, alterations being adopted to meet emergencies without any organized efforts towards revision of the system as a whole.

Probably the simplest plan to follow in this article will be to trace the path of a patient through the hospital and to indicate the various possibilities to be considered. This will afford a ready means for indicating the various subdivisions of the institution and defining their functions. Following this a few remarks on professional personnel and their economic employment will not be out of place.

The patient when first admitted will go into a reception division in which he is examined and studied with the object of determining the particular problems to be met and deciding the course of procedure to be adopted. As soon as this has been accomplished, a process which may take from a few minutes to several weeks, he will be transferred to the division in which it has been concluded he will receive the necessary treatment and care. This decision must be based upon the actual needs of the patient and not upon convenience in administration. This means that the various divisions must be organized upon a basis of therapeutic equipment.

At the time of admission the patient frequently shows more or less severe disturbances of conduct (often called the symptoms of acute insanity) which are reactions to the difficulties, of whatever nature, which have brought about the demonstration of faulty habits or behavior or, in other words, have precipitated the insanity. During this stage of acute mental disorder it may be necessary to await the arrival of a calmer period before attempting more active education and to confine our activities to meeting exigencies and dangers as they arise. This calls for expert skill and special equipment particularly in the nursing force. It, therefore, will constitute a separate division which may be called the division for acute mental cases. It should be constructed in small units to permit separation of patients and be planned especially to promote rest. Prolonged baths and conveniences for packs are essential. Facilities for simple employment, not as training but as an outlet for energy, must also be provided.

After the subsidence of this acute period, or immediately if such a stage does not exist, the patient should pass into a special division devoted to education. Such a division must provide for various kinds and grades of instruction and must be regarded as the most important branch of the institution. Upon the success accomplished here the whole future of the individual depends. Its functions correspond exactly with the reconstruction work which is being planned for disabled soldiers after the wounds causing the disability have sufficiently recovered. This division should be able to provide material assistance to the Government in planning and carrying out such work.

It will be realized that, following the abatement of the acute stage of mental disorder, the condition of the patient may vary enormously. Let us take two extreme illustrations. The first patient is stupid, careless and untidy, shows little or no evidence of interest in his surroundings and, as is often said, is in appearance more or less completely demented. In most hospitals such patient is promptly transferred to the "untidy" or "back" wards of the institution, there to receive a postgraduate course in idleness and degradation. The proper destination of such individual is an environment in which continuous efforts are made to arouse interest and to rehabilitate the former self-respect. The man may have to be trained like a baby even in the simpler habits of self-care but if nothing more than this is secured the problem of his maintenance in the institution becomes enormously simplified. In connection with the treatment of such cases various stimulating forms of treatment, hydrotherapeutic, diversional and otherwise, are important.

At the opposite extreme, the subsidence of the acute stage may be followed by an apparent return to the individual's previous norm. He is then said to be convalescent. He is, however, not necessarily ready for discharge. The problem to be faced concerns not only his immediate recovery but still more the question of the prevention of future breakdowns. This may require special and even prolonged training in suitable habits of reaction and industry with the object of equipping the man better to meet the conditions of life on the outside.

Between these two extremes lie every possible gradation and variety each with its special problems, the number being almost as great as the number of individual patients.

The functions of this educational division are those of habit training which is to be accomplished by graded occupational teaching and the provision of graded responsibilities. It should be the prime object of the hospital to see that every patient who leaves the institution is better equipped to meet the world than when he entered, and that those who remain shall be prepared to be made useful to the full limit of their capacity.

As a result of the information gained from a study of the patient under these conditions and the progress he makes as a consequence of the training, there will develop, in the course of a variable time, definite grounds for the determination of the future mode of life which it is desirable for each to adopt. This may be life outside the institution (with or without certain restrictions) or, on the other hand, it may be more or less permanent segregation from the complicated conditions of life in the world.

Leaving for the moment those persons who are discharged from the institution we may consider the division of the institution devoted to the care of those who will remain permanently within its walls. This division, the largest in most state hospitals, must be designed with a view of providing varying degrees of complexity of environment (which is largely a question of individual responsibility) and also toward making the lives of the inmates as comfortable and as homelike as possible. This does not imply either a hospital life or a life of idleness. To be happy every individual must be occupied. The form of occupation should be selected by reason of its fitness and interest for the individual, but here due consideration for the needs of the institution itself is permissible. The custodial division is thus also the industrial division. Not only will economy in administration be promoted by this arrangement but the welfare and happiness of the inmates will be greatly enhanced. Systematic industrialization of the state hospitals is a most urgent need, for nothing is more detrimental to the patient or more heart-rending to the observer than the rows of idle, so-called dements who fill their "chronic" wards.

The training given in the educational division may well be planned to prepare such patients as are expected to stay within the institution for the performance of the various kinds of industrial work which are being undertaken by the institution.

It cannot be too strongly insisted upon, however, that occupational therapy, the name customarily given to the work of the educational department, is absolutely separate and distinct from industrial employment. The latter may, indeed, be regarded as graduate work, but in no case should the industrial needs of the institution be put ahead of the therapeutic requirements of the individual patient. The case of the institution, in this regard, does not differ from that of the world at large. A child is educated first and only later is permitted to enter industry. To attempt to interfere with this provision in ordinary life has always led to disaster. This is evidenced by the enactment of laws prohibiting child labor and even more emphatically during the war, both in this country and in Europe, when efforts were made to relax the school and training conditions in order to allow early participation in work essential for the conduct of the war. Universally it has been found that there followed an enormous increase in juvenile delinquency. We may well apply this experience to the state hospitals and realize that an effort to cut down or eliminate the training period is bound to lead to failure.

The organization outlined thus far then provides for the following divisions:

1. A reception division,
2. A division for the care of acute mental cases,
3. An educational or reconstruction division,
4. A custodial or industrial division.

To these must be added

5. A hospital division,
6. An infirmary division,
7. A laboratory division.

The hospital division has as its function the treatment of the physically sick and will require medical and surgical equipment similar to those of a general hospital. It must also provide for the care and segregation of various infections such as tuberculosis and the contagious diseases.

The infirmary division is a department in which the more or less helpless results of organic disease are cared for, the terminal stages of general paralysis of the insane, senile dementia, etc. This should contain the only untidy cases permissible in the institution, cases in which the lack of self-care is due to structural defect and not merely to bad habits. These latter make up by far the larger proportion of the inmates of the "untidy wards" of most institutions.

The laboratory division needs but little description. Its functions correspond with those of any well-equipped general hospital.

The organization into divisions here outlined does not differ greatly perhaps in its general arrangement from that which obtains in many hospitals. I would insist, however, that it does differ in that it presents a clear definition of the functions to be performed and is built up around an eminently practical plan of therapeutics.

The personnel of a hospital can profitably be divided into professional and administrative branches. This subdivision means something more than mere words. I am convinced that if its true significance is realized and acted upon that very considerable economy in material may be accomplished.

The professional branch, with which alone I propose to deal, includes the medical, nursing, attendant and special therapeutic services. For all such work special, and often prolonged, training is necessary and it is in these fields particularly that the greatest demands are being made by the army. It is obviously wasteful to employ a highly trained individual to perform work which could well be done by unskilled persons. In the hospital, organized as planned above, the great need for physicians trained in psychiatry obviously lies in the receiving, acute mental and educational divisions and it is here that they should be especially concentrated. The work in the hospital, infirmary and custodial divisions can be carried out by physicians of less psychiatric experience, but there should be some arrangement whereby cases requiring special study could receive the benefit of such experienced physicians as are available. For this purpose it would be well to provide certain wards for special observation which could be under the same direction as the more acute services. Under present conditions laboratory work, which will of necessity be largely routine, can be placed in the hands of trained women technicians.

A great deal of a physician's time in state hospital work is often wasted in performing simple routine duties which could well be delegated to a clerk or some similar person. We have recently instituted in the Illinois hospitals a system whereby a clerk is employed to act much as a secretary to the medical staff. By observing certain rules for minimum requirements she is able to keep track of the duties which should be carried out each day, to see that patients and records are in readiness for the physician, that the purely formal data in various reports are filled in and, by making appointments with visitors, to see that unnecessary interruptions of the physicians' time are avoided. The system also enables one experienced physician to arrange his service so that much of the necessary routine medical work can be allotted by him to assistants (women or men unfit for military duty) who perhaps are not trained in psychiatry. This has resulted in a very marked saving of time and greater efficiency in spite of the reduction in the numbers of trained physicians available which we, in common with other states, have suffered.

The nursing service can be improved in like manner by cutting out unessentials from the duties of those who are trained. The training of nurses for psychiatric work is another field, the importance of which has been brought home to us by the war. Most hospitals today maintain training schools for nurses, but unfortunately the training given takes but little account of the special work that these nurses are to be required to do. It aims rather at producing a nurse cast in the same mold as the nurse in a general hospital. In my opinion our training schools should be planned to develop nurses fitted to care for mental and nervous cases and we should hire, already trained, such nurses as we need for the care of bodily sickness. We have been working on such a scheme in Illinois for the last few months and hope to have the new training school at work this coming fall. The backbone of this course must be habit training and occupational therapy which we have adopted as the corner stones of our divisional organization. Such nurses will be required only in the earlier divisions considered. Attendants, adequately trained, will be employed for the care of custodial cases.

In the educational division there are needed workers especially trained in occupational teaching. Much of this work will be done by nurses of the special training school alluded to but, for the present at any rate, it seems necessary to secure some one who can devote the whole time to the supervision and direction of the activities in this division. This, of course, does not relieve the psychiatrist from the duty of deciding and prescribing the proper treatment for each individual.

Lastly, reference must be made to a division the work of which lies in part outside the walls of the hospital, the social service department. The state hospital, from the nature of conditions, possesses almost a monopoly upon psychiatrists and is unquestionably the center from which must radiate all efforts toward prevention and after-care. The staff must be so organized that the physicians can take part in the mental hygiene work of the community and there should be some provision made for the reception of patients for temporary study and observation with the object of determining the proper treatment necessary.

Reference was made above to the maintenance of special observation wards in connection with the acute (as opposed to custodial) service for the special study of difficult cases. These same wards should also be open for the reception of "temporary care" or voluntary cases brought in from the outside for diagnosis and not necessarily subjects for commitment. It is this class of case which is being brought more prominently forward by war conditions and which the state hospital must be prepared to assist.

SUPERVISION OF THE FEEBLEMINDED IN THE COMMUNITY*

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THE social significance of feeblemindedness is becoming increasingly apparent each year. In the impression which it has made on the popular mind as a practical problem demanding a practical solution it has far outstripped the more interesting and difficult question of mental disease with which it is so closely allied but which is still a comparatively unknown quantity even to the more enlightened. To one who works in the field of mental disease, there is something very heartening in the familiarity which the ordinary teacher or social worker now shows toward feeblemindedness as a possible factor in her work. This quite general recognition of the importance of mental defect for the community in marked contrast to the prevailing ignorance of the social importance of mental disease is not difficult to explain.

Of all the problems presented by mental hygiene, feeblemindedness is the simplest, most accessible and most easily comprehended by the common man. Anything that can be stated in terms of intellect is simple compared with that which goes over into the fields of emotion, feeling, impulse and instinct. It may be that such a confining of feeblemindedness to the intellectual sphere will prove to be an over-simplification of the problem, but the fact remains that this way of looking at it has made it easy to explain and easy to understand.

This accessibility of the intellectual factor in feeblemindedness has also made it one of the first problems to lure academic psychology into the practical field, for the intellect is much more readily open to experimental laboratory methods than the will or the emotions. There is no question but that the swift rise of the mental test as a center of interest and experiment in applied psychology has had much to do with the growth of popular recognition of feeblemindedness as a social problem. Parallel to this development of psychology and aided by it has been the advance of criminology which by its disclosure of the intimate relationship between mental disability and antisocial conduct has perhaps done more than any other one thing to force the problem of feeblemindedness upon the public.

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*Read before the Mental Hygiene Section of the National Conference of Social Work, Kansas City, May 15–22, 1918. General topic of the symposium of which this was a part, "Steps Necessary in Community Control of the Feebleminded."

Organized charity with its unimprovable cases, agencies dealing with illegitimacy and sexual immorality of all kinds—all these have added their weight to the movement. Then still closer to the mass of the people comes the public school, so long trammeled by the presence of the feebleminded child who by definition is the stumbling block *par excellence* in the way of all orthodox teaching. In the recognition of the feebleminded child the school is on the way to a solution of one of its most serious problems, and the altering of an entire school system to make special provision for such children has done much to enlighten the common people.

It only remains for the final impetus to come from industry now strained to the last notch by the demands of the war. The recognition of the part played by the feebleminded workers, combined with the problem which mental deficiency is making for the new National Army as shown by the discharge of more than 4,000 feebleminded soldiers ought to give all the additional push needed to bring the country to a complete realization of the necessity of working out a plan for state control.

While feeblemindedness as a problem in mental hygiene may be comparatively simple, as a problem requiring definite social action it could hardly be more complex. It is the old question of reconciling the welfare of the individual to the good of the community which is particularly trying when the individual in question is not capable of taking his own part. How can modern society prevent the feebleminded population from becoming a dead loss economically? How can it guard itself from the injury which the feebleminded have the power to inflict upon the present and upon future generations and still be fair to individuals, the majority of whom have a certain right to life, liberty and the pursuit of happiness comparable in a degree at least to that of children whose interests we guard so carefully. Moreover we have to remember that the feebleminded person especially of the moron group is not an isolated individual without family ties. He belongs to a home whose love for him and belief in his possibilities will have to be taken into account in any plan we may formulate. No plan which ignores human relationships and public sentiment will be successful, although innumerable laws confirm it.

If we approach the problem in cold blood, we may say that the only questions to be considered are the prevention of propagation on the part of feebleminded persons, the prevention of delinquency, and the most effective utilization of the labor represented by the feebleminded population. Nothing is simpler than to give the logical solution to these problems. The reason such solution is not simple in practice is that human life is not primarily logical. We are still a long distance from conscious intellectual control of social life, and even so the most rigorous intellectual control would obtain its results only through taking into account the working of human impulse and emotion.

Sterilization of the feebleminded is logically the solution for the problem of prevention of propagation of the mentally unfit where feeblemindedness is due to heredity. Practically, despite legislation, it has never worked because it is a purely intellectual remedy. It has never considered the prolonged period of preparation and education necessary to change deep-seated primitive attitudes. There may come a time when sterilization of the unfit will be incorporated in our program but it will be only when the general level of enlightenment on social problems is materially raised by slow growth.

Segregation much more than sterilization offers a practical solution to part of our problem at least and may eventually be the final, most practical solution. At present it fails in two, possibly three, respects. First, on the human side, when by segregation we mean a fairly complete shutting off from society of all the feebleminded including types of the higher grade, we ignore a profound aversion on the part of people in general to confinement for life for any human being, particularly when no offense has been committed commensurate with such punishment and when the individual to be segregated seems to the ordinary observer not to be very different from himself. This combined with the feeling which relatives, particularly of the high-grade feebleminded, have against segregation, makes any very complete program of this kind quite impossible for some time to come.

Quite aside from the obstacles presented by popular sentiment, there is one fundamental difficulty in the way of segregation as a complete program, on the purely economic side, and another which may or may not be fundamental. If the most conservative estimates regarding the percentage of feebleminded in this country now under suitable institutional care are correct, it still remains to provide institutions for at least fifty per cent of the total feebleminded population of the United States. According to Mr. Kuhlman in the Journal of Psycho-asthenics for September—December, 1916, estimating that five-tenths per cent of the entire population is feebleminded, not five per cent of the total feebleminded population is now segregated in institutions for the feebleminded. Even if one disagreed with this estimate, it could be made far more conservative and still leave us with the task of housing a tremendously larger number of feebleminded than any state has ever contemplated. Any approach toward complete segregation is bound to mean a construction of institutions on a scale which will postpone realization of the scheme to an indefinitely distant future. In the meantime the feebleminded are with us, at large in the community for good or ill, with no conscious control of the situation on our part.

The other point to be considered on the economic side is the utilization of the labor of the feebleminded. We have no conception at present of how much of the rough work of the world is being done by morons. We are just beginning to get some return from the labor of the feebleminded in institutions through the rise of the colony plan in a few states. But we have no basis for deciding at present whether segregation can ever be made to utilize the labor of the feebleminded to as great economic advantage as some other plan which would allow of the employment of feebleminded in the industry of the outside world. This is a question for consideration and for further investigation that we may gain facts upon which to make a judgment.

Practically, then, sterilization from the point of view of human prejudice and segregation from the standpoint of human rights and economic possibility do not constitute an adequate program for the care of the feebleminded population of the country at least for the next quarter century. Even though we press sterilization into service just as far as popular sentiment can be made to tolerate it and though, regardless of sentiment, we construct institutions to the limit of the common purse, making full use of the cheaper plants offered by the colony plan, we shall still have a large problem untouched in the feebleminded at large in the community. Shall we continue for the next twenty-five years to depend entirely upon segregation and remain in ignorance of the facts regarding the lives of the feebleminded outside institutions?

How can we decide whether all the feebleminded need segregation, how can we be sure that every feebleminded person is a potential delinquent until we know how many of the steady though humble and unskilled workers of the world are intellectually superior to the feebleminded delinquent or segregated case in the institution for the feebleminded?

Our knowledge of the feebleminded is based almost entirely upon our knowledge of intellectually inferior individuals who make trouble for us in society. Is it impossible that there is a class of individuals who by any intelligence test will measure down to the level of the institutional cases whom we label feebleminded, but who are not social problems? The whole question of feeblemindedness seems to be complicated by the question of how much of the antisocial or inefficient conduct of the types of higher grade may be due to the intellectual defect and how much to the emotional make-up. That is, may there not be as much temperamental variation in the feebleminded as in the intellectually normal? And that being the case may not the standard of feeblemindedness indicating segregation be as much a matter of type of emotional and impulsive make-up as a matter of degree of intellectual defect?

In other words, we seem never to have made any real attempt to study the problem of the feebleminded in the community to determine (1) whether there is any class of people apparently feebleminded by our intelligence standards that actually does get along in the world (2) to determine what real supervision, intelligently conceived and applied, can do to make the existence of certain feebleminded individuals outside of institutions safe and economically advantageous to society when it would otherwise not be so (3) to find in how far the so-called feebleminded delinquent is innately vicious and how far he is the result of prolonged maladjustment due to defective intellect, emotional and impulsive make-up, complicated by bad environment and training; i. e., may it not be possible that even in the field of intellectual defect the insight of modern psychiatry as to the mental mechanisms which produce maladjustment in the intellectually normal may have a bearing?

The *best plan* for supplementing segregation and sterilization for the present, even though they should ultimately prove to be the only solution to our problem, the *only way* to obtain the kind of information we need and must have about the feebleminded, the *best scheme* for educating the people to a comprehension of the problem and a willingness to accept segregation and sterilization when necessary, is, it seems to me, the plan for careful scientific supervision of the feebleminded in the community as part of a state or nation-wide program for control and prevention of feeblemindedness.

I have no theory that the majority of the feebleminded would become industrially efficient, sexually safe or economically self-supporting, if only they could be supervised. I have no illusions regarding the difficulty of providing anything approaching adequate supervision, but I am convinced that for the present there is no other way of getting at the problem and after all, it is not as if we had not already taken upon ourselves responsibility for trying out such plan when we began the movement for ungraded and special classes for feebleminded children. Is that work all to be wasted? Are we to look after these children until they are fourteen or sixteen and then suddenly throw off all responsibility even to the extent of making no attempt to provide institutional care when it is obviously needed?

The school and the ungraded class give us the nucleus for a system of supervision which could be worked in so simply that it would not only not meet with opposition but would be welcomed by the children and by the parents.

In order to make such system of after-care effective in a school system, three things are essential: (1) an adequate mental clinic under the direction of a psychiatrist with psychological training or of a psychologist with psychiatric viewpoint and experience. This clinic ought to provide a routine method of passing on the mentality of every child who enters school in order that the assignment of the child to a special class should not depend chiefly on chance, and should not be delayed for several years while the child is struggling vainly in the regular grade and getting the full effects of his maladjustment. This clinic should be the center for a system of registration for the direction of social service and after-care and for the vocational guidance of the feebleminded child both in his industrial training and in his placement after he leaves the school. (2) The second essential of supervision is social service from the time the feebleminded child enters the special class. If a trained social worker with psychological background could act as visiting teacher for the special or ungraded classes, keeping in touch with both child and home, following the child's development, keeping track of his conduct out of school, educating his home to a right attitude toward him, helping him to use the best recreational conditions the neighborhood affords, when the time came for that child to leave school, the combined knowledge of the teacher, social worker and clinic director ought to give a reliable basis for deciding what should be done with him. They would know what his abilities were, what his chance of industrial success, what his tendencies to antisocial conduct and, if he seemed to demand institutional care, the friendly relationship with the parents built up by the social worker would offer the best possibility of inducing the parents to permit segregation.

(3) The third necessary factor in a system of supervision is a vocational and employment bureau which shall be merely another phase of the mental clinic and the social service. This bureau would not only attempt to place the feebleminded child in an occupation for which he was fitted, but it would continue to supervise him carefully through the social service worker. Such supervision would do much to keep the feebleminded child steadily at work, not only because the worker could come in at a crisis to help adjust his difficulties and tide him over a period of discouragement, but because the worker would explain the child to the employer and through her ability to adjust problems as they arose would make the employer willing and able to keep a class of workers who might under ordinary conditions be impossible. The bureau would have to work up the whole problem of employment of the feebleminded—finding where the feebleminded child can best be utilized, interesting employers in the possibility of making conscious use of feebleminded labor, inducing them to try various experiments with such labor under supervision.

It may be argued that this system to be at all adequate would be expensive out of all proportion to the results. In answer to that it may be said in the first place that we know nothing about the results, certainly not from any experience in this country. In England and Germany and one or two other countries, a certain amount of after-care has been tried with rather poor returns in the case of England and apparently good ones in the case of Germany. I very much doubt whether such after-care has been done with any but volunteer workers and under any but fairly haphazard and unscientific direction. It seems to me we shall have no grounds for judging the effectiveness of a careful scientific system of community supervision, until we have given at least a five-year trial.

As a supplement to supervision through the school system, we have in the institutions for the feebleminded, especially those with the colony system and field agents, machinery all ready to our hand for the supervision of institution cases who have improved with training and proved themselves fit for a greater measure of freedom. The institution for the feebleminded is also the logical laboratory center for the schools in its district, and school and institution might well combine on a thoroughgoing plan of training and community supervision wherever possible.

That supervision will be expensive, there is no doubt; but there seems to be no way to avoid the expense entailed by the production of the unfit. Segregation is expensive, special classes are expensive,—although perhaps no more so than institutional care for children who are too young to make any return in productive labor,—the feebleminded at large in the community unsupervised are expensive. It is not a question of whether we shall or shall not pay for the care of the feebleminded. It is merely a question of whether we shall pay blindly or consciously, whether we shall pay in crime, in courts, in reformatories, in prisons, in almshouses, or whether we shall pay in directed care calculated to give us the facts which may in time make control and prevention of feeblemindedness possible.

It may be argued that such scheme is impractical because of the numbers to be supervised and the necessity for real supervision if the plan is to amount to anything.

From one point of view any complicated extensive task involving care of many human beings is impractical, it is never done simply or easily. The effective education of children in schools is a gigantic task, seemingly almost impossible of accomplishment. But we never consider abandoning it because results are not always ideal or economically profitable. Successful supervision in the community is coming to be the final aim and ultimate criterion of achievement, for the hospital, the prison, the court, the reformatory, and the hospital for the insane. We call these systems probation, parole and after-care, and no one questions their value or measures them by their economic advantage. It really is not a question of whether or not a system of community supervision of the feebleminded will be simple or cheap.

It is a question of when we are going to begin to do this thing which has to be done before we can get any farther with the problem of feeblemindedness, and how long we are going to flatter ourselves that the money for ungraded classes is well spent while supervision ceases when the greatest need for it begins. There is no use training children for the scrap heap. If supervision is too expensive, ungraded classes are rank extravagance.

Finally, to sum up, a system of community supervision of the feebleminded in connection with the school system is absolutely necessary for a term of years, (1) in order to deal with the problem of control and prevention of feeblemindedness while segregation and sterilization are as yet inadequate, (2) in order to get facts regarding the feebleminded who can and those who cannot be adapted to life outside an institution, (3) in order to determine whether there is anything better than the colony plan for utilizing the labor of the feebleminded, (4) in order to educate the community to an understanding of the problem, (5) in order to justify the existence of special or ungraded classes and render them really useful, (6) in order to provide an opportunity for the study of the individual cases not *a priori* delinquent or belonging to the group obviously requiring segregation.

Dr. L. Pierce Clark in a recent article* has put the matter in a nutshell when he says: "We shall never arrive at any proper understanding of the causes of prevention of feeblemindedness until we reconcentrate ourselves anew to the individual case studies and make them thorough and detailed and see where they lead us, instead of studying this class *en masse*, which has been the popular mode of late. . . . Psychopathic traits, or, better, conduct disorders in the mentally-retarded and arrested children, need to be considered and studied on the broad plane of our present-day knowledge of personality and psychiatry."

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* MENTAL HYGIENE, v. 2, p. 23–33, January 1918.

THE NEXT STEP IN THE TREATMENT OF GIRL AND WOMEN OFFENDERS*

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Reformatories for women are not now meeting the needs of the women sentenced to them by the courts. We reach this conclusion from a conviction that with so poor a tool no worth-while result can be achieved.

A reformatory which receives women from all the courts of a given state has within its walls a group of people whose only common denominator is crime. How diversified such a group may be is shown in Chart 1, which is an analysis of the population of the Reformatory for Women of Massachusetts in 1915.

CHART 1

	No Nervous Defect	Neuropaths	Psychopaths	Epileptics	Hysterical	Total	Total Per cent
Imbecile	5	0	1	0	0	6	1.2
Moron	33	16	4	15	6	74	14.8
Subnormal	40	49	22	25	9	145	29.0
Dull	36	32	11	15	8	102	20.4
Fair	24	10	13	13	8	68	13.6
Good	44	24	11	13	13	105	21.0
Total number	182	131	62	81	44	500	
Total per cent	36.4%	26.2%	12.4%	16.2%	8.8%		100.%

To turn such a group as this into a family whose chief purpose is re-formation of moral standards is to attempt the impossible. They have no common sympathies, no mental loyalties, no common ideals.

Let us forget, for a moment, that we are talking about reformatories or prisoners. Just suppose, for the sake of argument, that we are discussing a new state project in which it is proposed to build an institution to house epileptic, feebleminded, psychopathic, hysterical, neurasthenic, and normal women, who range in mentality from imbecile to high-school grade, with twelve per cent illiterates, foreign and native. One immediately sees how impracticable such a plan is. If such a group were to be brought together for any single reason, for appendicitis, for heart trouble even, one would pity the administration.

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* Read before the National Conference of Social Work, Kansas City, Mo., May 15–22, 1918.

This is, however, the situation of our reformatories because this is the kind of population going through our courts, since no state has developed the policy of caring for its criminal women on the basis of an analysis of its criminal population. Reformatories, therefore, cannot meet the needs of the criminal women because they are not equipped to handle so complex a share of the state's burdens as falls to their lot.

A state reformatory or state training school should not transfer sane patients nor discharge them into the community as "unfit subjects," short of the maximum sentence, unless cured; it should make of itself the state laboratory on delinquency and by its studies should shape the state policy for the treatment of *all* of the state's delinquent women. There should be no tag ends to relieve administrative strain; the tool, by which I mean the reformatory, should be made strong and flexible enough to do the job so that no phase of the woman criminal problem should be left untouched. We ask, at last, to be conscious of it *all.* By conscious, we mean having a full realization of the needs of each prisoner and the possibility of fullfilling those needs, be they re-education with a view to reinstatement in the community, or hospital treatment to correct nervous defect, or permanent custodial care. The question may well be asked why mix hospital care with reformatory treatment; that is, hospital care of the kind required for the treatment of psychopathic and neurasthenic women, with reformatory treatment, which used to mean fitting people for community life. The answer is that the next step in the treatment of criminal women necessitates such action.

The states which build reformatories now are either going to begin shortly to transfer their unmanageable types to the state prison (that is, to the female annex of the men's prison), or what is just as bad, there will be agitation for the building of a women's prison to relieve the reformatories of their unruly inmates. An unmanageable woman prisoner is so because of nervous or mental defect, or both, and no prison discipline will overcome that defect. If the Women's Reformatory of Massachusetts, an institution with forty years' experience, has done nothing else for the cause of the criminal women, it has demonstrated that no women's prison is necessary; that no men's prison should have a female annex; that women prisoners should not be classified according to age or crime. It was built to duplicate, as nearly as possible, the men's prison. Time and use have modified its work; it has 60.7 per cent misdemeanants, 37.6 per cent felons, and 1.5 per cent lifers. So far as these crime designations go, they have no influence on our work; it is the personality of the woman that counts; it is the type to which she belongs which affects her harmfulness or helpfulness in the institution group, and which determines the kind of treatment she must receive. This being true, what is our next step?

Women criminals divide themselves roughly into three groups:

1. Those who may safely be returned to the community after training.
2. Those who need permanent custodial care.
3. Those about whom prognosis is doubtful, because they have formed the disciplinary problem wherever they have been, and for whom no method of treatment has been worked out.

With the plan of Chart 1 as a basis, Chart 2 has been drawn up analyzing the 5,310 women criminals of Massachusetts who were on probation or sentenced to institutions in 1915, the year for which Chart 1 was made. I realize that such an analysis can only be tentative, but it is good material from which to argue.

CHART 2

	No Nervous Defect	Neuro-paths	Psycho-paths	Epilep-tics	Hyster-ical	Total	Total, Per cent
Imbecile	53 1.0%		11 0.2%			61	1.2
Moron	350 6.6%	170 3.2%	43 0.8%	159 3.0%	64 1.2%	786	14.8
Subnormal	425 8.0%	520 9.8%	221 4.1%	265 5.0%	96 1.8%	1540	29.0
Dull	382 7.2%	340 6.4%	117 2.2%	159 3.0%	85 1.6%	1083	20.4
Fair	255 4.8%	106 2.0%	138 2.6%	138 2.6%	85 1.6%	722	13.6
Good	467 8.8%	255 4.8%	117 2.2%	138 2.6%	138 2.6%	1115	21.0
Total	1932 36.4%	1391 26.2%	660 12.4%	859 16.2%	468 8.8%	5310	100.0

			Number	Per cent
Group 1	░	Normal	1,104	20.8
Group 2	▧	Feebleminded	850	16.0
Group 3	▨	Subnormal Neuro-psychiatric	3,356	63.2
			5,310	100.0

Given this as the woman criminal problem, it is surely obvious that a "reformatory" as we now think of that institution, cannot meet the needs of these women. Is it evident that a "reformatory" is not even necessary? Has the time come to give up "reformatories?" Are they going out?

In 1915, probation in Massachusetts carried 2,783 women. This chart says there were only 1,104 mentally and nervously normal women in all that year. Probation then was hampered with a large number of women who should never be dealt with on probation. Could probation handle all normal women who commit crimes? Numerically, yes. How about putting a murderess on probation? It has been done and done successfully. There should be no limit to the possibilities of probation of normal women, because probation has all of the community resources at its disposal. Because of its low per capita cost the state could well afford to keep the number of probationers to each probation officer low. Probation officers would know better than I whether their technique would meet the needs of a criminal population of normal women of this size. Theoretically it should be able to do so.

The second group are those who should have permanent custodial care. There are, in this analysis, 850 feebleminded women who would need such care. These women should form a farm colony group in buildings of the simplest construction. Perhaps when their restlessness for city life wore off, they might be given under good leadership the problem of reducing the state's importation of poultry and eggs. They might—we may be too optimistic—with a combined truck garden, poultry farm, and light state-use industries for instance, be made self-supporting. However that may be, with their defective minds they should never again be called criminals, and they are not reformable in the reformatory institution of today.

The third group are those about whom we know the least. They have formed the major disciplinary problem wherever they have been and were long supposed to be just bad. In some institutions they are chained to the floor, the administration being utterly at a loss how to manage them. At an earlier stage of our social history one can imagine them being burned as witches; they certainly act possessed. If they were to commit murder, a plea of insanity might be filed, but when they are torturing themselves or the administration or fellow prisoners, alienists will not call them insane, and insane hospitals discharge them. Have they a socially available norm of conduct? This is the crux of the next step in the correctional treatment of criminal women. The question can never be solved by a reformatory as we know that institution.

The problem is not one of giving in to the whims of nervous women; it is not a question of conduct color-blindness on their part, but a question of basic nervous defect as real as the loss of an arm is real to the physical body or as insanity is real to one's mental self.

A psychopathic or epileptic woman is a nervous cripple; her struggles for social adjustment are those of a soul pent up in an uncongenial body; every struggle she makes plunges her deeper and deeper into behavior complexes until the last stage is worse than the first.

Do you ask the question, "Why is this a reformatory problem?" Because her conduct creates a public order, police, court problem; i. e., a crime problem; and, of course, the word re-form does not preclude medical care. It excludes nothing, no effort that will remake the individual. Those who are in this work have the right to unlimited materials to aid them. Reformation does not mean, *keep that prisoner safe from doing harm to me;* but rather, *make that prisoner over so that she may join me safely in the community.* No tool, no material, no science, no skill should be withheld; and so it is that we ask for separate colony groups for these various types—colonies on the cottage plan, so that within the colony there may be classification of degrees of defect. Each colony must be complete in itself, entirely homogeneous, and quite distant from any of the other colonies on the reformatory grounds.

Treatment will start from the type standpoint. It will no longer be purely a moral-conduct readjustment problem, but predominately a medical-psychiatric treatment of conduct problem.

The next step, then in the correctional treatment of girl and women offenders is a new kind of reformatory—one that shall be organized and administered on the principle that the individual needs of the persons committed to it must be carefully studied; that individuals must be classified into proper and distinctly separated groups; that each group shall be given the special care and treatment that its members require, and that the care and treatment shall focus itself not only upon the physical problems involved, but especially upon the psychiatric problems which are the predominating factors in the delinquent careers of these women.

CHARACTER AS AN INTEGRAL MENTALITY FUNCTION*

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THE recognition of character as a major mental function in personality study is validated by the citation of a few simple psychologic considerations. Observation of the familiar but inscrutable phenomena of healthy mental functioning discloses the two essential, interdependent, inextricable components of mentality to be intelligence and character (moral force, stamina). Clouston says, "Above all it (psychology) must aim at providing a full and accurate account of those most fundamental elements of our constitution, the innate tendencies to *thought* and *action* that constitute the native basis of mind." (Italics are ours.) These are the essential means of expression for different, though blended or interacting, mental functions.

The next step in analysis refers these constituents to their respective functions in the "native basis of mind" and finds them to be intelligence and character. What logical conclusions may be drawn from the premise that intelligence is the primary function of thought and that character stands in the same relationship to action? The subjoined, tentative, categorical arrangement of some of the principal mental functions may assist in answering this question.

OUTLINE OF MENTALITY STUDY†

- Mental Integrity
- Mental Disorders
  - Mental Functioning in
    - Mental Health } (manifest in symptoms)
    - Mental Diseases }

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† In devising and adapting this tentative working scheme, grateful acknowledgement is accorded Major A. J. Rosanoff of Kings Park Hospital for his "Classification of Mental Diseases" and Dr. Walter E. Fernald, Superintendent and Director of the Psychopathic Clinic of the Massachusetts School for the Feebleminded, for his "Fields of Inquiry" under Intelligence Deficiency.

Fields of Inquiry
- Physical Condition
- Heredity, Environment
  - Constitutional disorders
    - Recoverable psychoses
    - Recurrent psychoses
    - Chronic psychoses without deterioration
    - Chronic psychoses with deterioration
    - Epilepsy
    - Huntington's chorea
  - Disorders of exogenous origin
    - Traumatic psychoses
    - Alcoholic psychoses
    - Syphilitic psychoses
  - Other groups
    - Senile psychoses
    - Arteriosclerotic psychoses (non syphilitic)
    - Brain tumor
    - Cretinism and myxoedema
  - Disorders of uncertain nature or etiology

Mental Functioning in
Intelligence Integrity } (manifest in decisions)
Intelligency Deficiency }
(in terms of mental level or I. Q.)

Fields of Inquiry
- Physical Condition
- Heredity, Environment
- Volitions, Inhibitions, Motives (selective)
  - Habits of thought, Reason, Judgment
  - Memory, General Information
  - Association of ideas, Initiative (planning)
  - Scholastics, Religious Training
  - Foresightedness, Perception
  - Apperception, Description, Imagination, etc.

Mental Functioning in
Character Rectitude } (manifest in behavior)
Character Deviations }
(in terms of variety and degree)

Fields of Inquiry
- Physical Condition
- Heredity, Environment
- Volitions, Inhibitions, Motives (operative), Instincts
  - Habits of Action, Disposition
  - Temperament, Emotionality, Sensibility
  - Impulsiveness, Initiative (action)
  - Adaptability, Fortitude, Egotism, Honesty
  - Altruism, Control, Patriotism, Conscience
  - Loquacity, Attention, Suggestibility
  - Reactions to opportunity, competition, etc.

For the purposes of mentality study, intelligence may be conceived as the thinking, inventing, selecting, combining, planning, deciding function of mentality and character as the complementary mental function. Character then, is the emotivating, feeling, sentimental, instinctive, sustaining, energizing, executing or vetoing function of mentality, and as such it is integral. Intelligence being the directing factor is responsible for its own product—decision; and character being the energizing force is responsible for its own product—action. Habit is a factor in both these functions, but a controlled factor i. e. it may be influenced by the will. Volition and inhibition, though under direction of intelligence, owe their force to character. Sentiment, emotion and conscience are related to character rather than to intelligence, and both the latter are inseparable parts of one whole—mentality. If intelligence be regarded as the judicial department of the mind, then character is as truly the executive.

An appeal to a person who exhibits inordinate emotionality to exercise control is sometimes, though mistakenly, made in a way to indicate that the intellect is at fault. In reality the appeal is made to the power of control—character, not to the knowledge of the importance of control—intellect. Appreciation of the importance of control is swept aside, if involved, by the action of the emotional force—character, counteracted more or less effectively by the power of control—character, again. Intellect apprehends and connotes the ideas rousing emotional reaction and suggests control of expression; but character yields expression or inhibits it. One in pain stoically refrains from screaming not because he knows it will do no good to scream, but because his character enables him to repress his screams consciously—or allows him uncontrolled expression in spite of his knowledge. Intelligence is not responsibly involved in either the triumph or defeat of the scream impulse.

Character force makes for efficiency of personality not less than does intelligence superiority. In fact, of the two, character is the valid determinant of personality behavior; since what is done is more potent than what is planned. A mentality able to plan well but in which execution fails or is faulty, is inefficient or maleficient and may be regarded as showing character deviation or anomaly. The soldier ordered into an imminently fatal action may have a superior intellectual equipment which appreciates both the command and the sacrifice involved in obedience; but that in his mental make-up which enables the sacrifice and energizes obedience—or inhibits it—is something other than intellect; namely, his character, the resultant of his innate endowment plus his training.

The reference of responsibility for decision and action to intelligence and character respectively is not an exclusive dogmatic division outlining distinct provinces, but a categorical reference for clarity of thinking and is comparable with other psychologic distinctions and references. That this reference is practically demonstrable is seen when the trusted bank employee embezzles. His character deviation is the occasion of his failure notwithstanding his repeated decisions not to steal; and his character deviation is blamed by his own intelligence and character and that of the court for the act. That the actual cause of failure is to be found in intelligence does not relieve character of the burden of responsibility. The cause of a gunshot is the powder ignition of which the indirect cause or occasion is the trigger pull. But responsibility is referred to the trigger pull, the occasion of the explosion.

Whether rightly or wrongly the fact remains that the fundamental idea of punishment and amenability to the administration of justice is that of teaching the importance not essentially of selecting behavior wisely but of wise performance. No attempt has ever been made to *enforce* better thinking and deciding, only to induce it as a means to the end of better behavior. The enforcement of acceptable behavior, however, is and always has been the fundamental purpose of civil and criminal jurisprudence. This places behavior under control of volition, i. e., acting or executive volition rather than selective or judicial. Instinct and reason have always taught that responsibility rests proximately with the acting province of mentality and with the thinking province only remotely. In actual daily usage one may think whatever he pleases, so long as his acts do not contravene established legal or social forms. When an offender is of demonstrably limited responsibility because of intelligence defect, there may be judicial clemency; but when he is demonstrably deviate in character only, there is no clemency, only the more sternness. The law imputes responsibility then, not for the selection of acts, but for their performance and in so doing tacitly recognizes something which we have termed character deviations as susceptible of improvement, in effect, demanding an approach in behavior to that emanating from character rectitude.

Current popular evaluation of personality is not confined to an estimation of intelligence only. Character is consciously or unconsciously regarded not less consistently, as the measure of excellence and efficiency. We actually demand certain character standards or at least social behavior standards in the personalities selected for various activities; in employees, soldiers, business and professional men and especially in all teachers, statesmen and moulders of public opinion. To illustrate the distinction between these two functions in our thinking: we respect the loyalty of the feebleminded mother to her children when it is exhibited; but we deplore her inevitable neglect of their welfare. It is not the intellect but the character of our efficient enemy in Germany, that we despise. And to carry our illustration one step further: while it is our own intelligence that dictates our instinctive contempt for the Kaiser's principles, the dictation would be void without our character to express and enforce it.

No demonstration of the fact is needed that character development and deviation progress far beyond the close of the formative period of normal intelligence development. Thus the two are not coextensive. This is true also to a limited extent in cases of arrested intelligence development. In these cases character development or deviation is not wholly circumscribed by the deficient intelligence; though by no means independent thereof. Character modifications continue to be reflected in behavior after intelligence development ceases. Furthermore, it is to be observed that in the earlier years of the formative period which we have been accustomed to regard as terminating at about the age of twenty, character formation lags behind the normal development of intelligence; while in the later years of the period the developmental progress of character is much more pronounced and significant, outstripping and overshadowing the progress of intelligence in the evolutionary years at and after the close of the formative period. Studies of feeblemindedness in physical childhood are concerned with intelligence rather than with character. Personality studies of adolescents and adults on the other hand find the more potent and significant factors to be character or social behavior deviations. The child is not held to strict accountability for behavior since character is not yet sufficiently developed; while the adult is responsible unless the intellect can be arraigned. The reason for the observed failure of "Mental tests," adapted to childhood mental ages, to prove adequate to the classification of adult feeblemindedness, doubtless lies in the transcendent potentiality of character factors in the later developmental period.

It is conceivable that cases of a physical age well within the formative period of an intelligence capacity not far short of integral could largely overcome the effect of certain character deviations and build up a more nearly ideal character. In fact, our sometimes well founded confidence in the reformation of certain criminal cases finds herein its justification. And it may be found that the inexplicable economic success of certain cases apparently hopelessly handicapped by feeblemindedness becomes clear on the appropriate distribution of the handicapping factors between the rudimentary intelligence and the still developing character.

Character anomalies or social behavior deviations have been recognized as within the purview of psychiatric observation in personality studies; though they are not yet susceptible of measurement ("behavior disorders," "character defects" and "asymmetries"). Both intelligence defects and social behavior anomalies, however, lend themselves to recognition, classification, description and treatment. That which is clearly recognized and differentiated as an integral factor, though a complex one is the more readily outlined, described and measured. Many attempts have been made to discover a metric treatment for certain mental forces or elements, some of which we have included under character as a major mental function. Should the recognition of character as a major mentality function contribute to hasten the discovery indicated, that alone would be a sufficient *raison d'etre.*

For the purposes of a community survey, mental functioning in character deviations may be treated as on a parity with both that in intelligence deficiency and that in mental diseases as fields of mentality investigation, since each in its own province contributes to defeat and accelerates the tendency to dependency, though not necessarily equally. Neither bears a part-to-the-whole or inclusive relationship to the other. By neither character rectitude alone nor intelligence integrity alone may the personality achieve entire efficiency. The juxtaposition and contrast of these two of the three fields of personality study enable ready consideration and correlation of decision and behavior, essential indices in their respective fields of intelligence and character. Moreover, the ready categorizing is possible of instincts, clearly not an intelligence function with other contributory and subsidiary fields of inquiry: e. g., selective inhibitions, initiative, reason, etc.

This conception of mentality and its inherent nomenclature makes for simplicity and clarity, since it enables the more clear definition or elimination of certain "ill-defined terms," e. g., psychopathic personality, constitutional inferiority, etc., which we have used while deprecating the necessity. The reason these have been unsatisfying is that they represent a symptom complex made up of factors from more than a single entity. These hitherto convenient and indispensable concepts may be replaced in case reports of healthy mental functioning by measurements of intelligence deficiency and by citing character deviations with their observed varieties and degrees. This procedure is conducive to a more searching analysis and a more incisive discrimination, since the essential functions of thought and action are categorically separated, and therefore hardly to be confused in case studies.

Innate intelligence defects are not remediable, though subjects of such make some slight improvement under favorable conditions and are in many cases capable of acquiring a certain proficiency in simple occupations under efficient direction. Character deviations on the contrary are at least susceptible of improvement under the direction of intelligence. Consequently, the recognition of certain fields of mental functioning, e. g., honesty, veracity, fortitude, as belonging in the province of character broadens the outlook for the substantial advance of certain cases toward character rectitude.

Psychiatry in a narrower sense deals primarily with mental diseases; but psychiatrists are daily distinguishing between cases of mental disease and cases of intelligence defect and are noting character anomalies. In these activities they are promoting social and mental hygiene as a definite aim. The suggestion is that this broad sociologic purpose of psychiatry as well as the intrinsic considerations of scientific accuracy will be better realized by recognizing character and its subsidiary mental functions as an integral field for investigation. The psychiatrist finds in behavior an indispensable element in the estimation of the sociologic menace of feeblemindedness in adult cases. In fact, whether from the viewpoint of legal status, sociologic efficiency, medical classification or popular evaluation, the determination of feeblemindedness in physical ages above childhood considers character, categorically or otherwise, not less certainly than intelligence.

Fields of inquiry which we have placed under character have been distorted occasionally into the province of intelligence, since they could not be ignored. Psychiatrical case summaries almost universally contain notations of character deviations, but hitherto these have seldom been made on their own merits. The point is that, since social behavior deviations are noted, clarity is more certainly secured by treating them as subsidiary to their appropriate major function. It is not the study of behavior and the notations thereon which have been neglected, but the recognition of character as an integral mentality function.

Certain cases reported in the following pages show intelligence to have been at least integral or of adult level in which character deviations stand out conspicuously as the predominant, if not the sole, cause of failure.

. . . .

Healthy mental functioning has two products or forms of expression—thought and behavior. Reference of these expression forms to their respective sources reveals intellect and character to be the mental functions involved.

Citations:

"Innate tendencies to thought and action . . . . constitute the native basis of mind."

Responsibility is referred to behavior rather than to intention or planning. This tacitly recognizes that which we have called character as integral.

Character as the immediate determinant of adult behavior makes for personality efficiency not less than does intellect.

Instincts, emotions, conscience and sentiments are subsidiary mental functions referable to character rather than to intellect.

The intellect dictates control of emotional expression while character exerts such control—effectually or ineffectually.

Intellect and character are synchronous in mentality development, but are neither coincident nor coextensive in either time or rate of development. Their relative importance is inconstant at any age level.

Personality studies of those of childhood physical ages are concerned less with character than with intellect since the former is then relatively rudimentary; but personality studies of adolescents and adults consider character the more intently as its dynamics increases.

Innate intelligence deficiency is stationary and irremediable, while character deviations are theoretically susceptible of correction while plasticity remains.

The recognition of character as a primary mentality function makes for clarity in psychiatric case study and terminology, and may perhaps hasten the discovery of methods of metric treatment.

Sociologically, a personality is more inimical whose character deviations are grave than is one which exhibits a grave intelligence deficiency.

In psychiatry and sociology as well as in legal and popular usage character with its subsidiary fields is immanent in personality evaluation both objectively and subjectively.

The eugenic and sociologic aspects of a population survey are more intimately seen, more clearly apprehended and recorded and more transparently represented when character deviations are recognized as an integral categorical entity.

What are the actual medical and sociologic results in the study and treatment of cases to be occasioned by the recognition of character and its deviations or anomalies as a major field of investigation in personality study?

Thus far our presentation has been an attempt to recognize psychonosologically the capacity for improved behavior observed to characterize certain groups of antisocial or dependent personalities. These groups will, apparently, comprise those of a sufficiently well equipped intellect to respond to an appeal to reason and self interest and to judicious training, i. e., those whose character is not beyond amendment. Such groups would include roughly, adolescent and young adult offenders, and dependents not mentally diseased nor deficient of the mental level of moronity. Most of these are not now in public institutions and none are to be found in schools for the feebleminded, e. g., young hoodlums and thieves, prostitutes, shiftlings, those of school age but neither in school nor at work. Some are in institutions, of course, such as orphanages, industrial schools, children's homes, reformatories, etc. Most members of these groups have missed a good or even fair home training, often because of disorganization of the home by death or divorce or desertion of parents or by parental neglect due to feeblemindedness. Each of these children has an individual sociologic problem that will hardly be solved without psychiatrical help. They are our potential criminals, prostitutes, malcontents and vagrants. The points to be noted are two: that these cases are salvable to economic productivity before character formation is complete and that propaganda for restoration would best be directed to character reformation.

That this vitally important sociologic need has been recognized by students, by public opinion and by legislation, and that the possibility of meeting the need has been popularly felt, is amply attested by the establishment of reformatories and special schools for such of the group as have become offenders. The methods and means hitherto applied have not been adequate for the task, however, partly because of delayed diagnosis and partly because of delayed remedial measures; but recognition of this fact and also of the allied facts that character deviations exist and that the possibility of correction of remediable character deviations, at least, rests on a sound scientific basis will go far toward pointing out effective means and methods. Psychopathic laboratories would not be needed inside penal and eleemosynary institutions if they were available outside thereof, where ready access might be had under favorable conditions through field investigators to the rather large numbers of potential offenders who might be not only prevented from actually offending but who, by the same process, might become productive social units. A very real need for authoritative psychiatric differentiations and determinations is keenly felt by charitable associations, childhelping agencies and public school teachers dealing at first hand with defective delinquents and backward children in all the many states without such an organized scientific institution.

The same urgent demand for mental hygiene which prompts the scientific organization of existing psychiatric agencies for the elimination of psychopathic menaces from among recruits and for the induction back into industrial activity of our returned veterans surely suggests the salvage of the salvable portion of these groups of potential dependents. The exigencies of the war have advanced by many years the time when this comparatively young country would have urgent need economically for methods of diminishing her dependents. But we of this generation find this onus suddenly thrust upon us. The relative numbers of dependents at home and at the front stands far differently from the ratio of even one year ago. It is idle to speculate with no basis of facts; but if each family head were a producer for four dependents public and private before the raising of our army, we may think of him as called upon to provide for at least three times as many now, counting the immense cost of maintenance at the front and the sums we contribute to the relief of our war sufferers. Such of the salvage suggested as is undertaken in this generation must obviously be in the hands of those remaining at home.

The need for psychiatric laboratories and for psychiatric staffs in states and municipalities where public institution heads may avail themselves of expert advice and correct diagnosis on cases urgently needing judicious social and economic disposal and characterologic treatment is now keenly felt not only by physicians, but by laymen also. The field so admirably covered by our Boston Psychopathic Hospital and other Massachusetts psychopathic clinics has been of inestimable value in educating public opinion to this need and to the availability of a scientific means of supplying it. Massachusetts is the leading state to act on definitely formulated plans to assist responsible deviates and the mentally disordered, as well as diseased, back to usefulness. Maine and other states look to the Psychopathic Clinic at Waltham and to other Massachusetts clinics as models, and are already canvassing the possibilities of establishing like institutions.

This field is open to psychiatrists pre-eminently since they are competent to differentiate mental disorders from the mental diseases encountered. Furthermore, they, especially are well equipped in methods, experience and trained personality to interpret and treat remediable character deviations. The community needs the nice discrimination, the exquisite psychiatric skill which distinguishes psychaesthenic and psychaesthetic states, but it needs also and especially in these days of war stress and necessity for conserving man-power, the devotion of our trained energies at home to the practical and not less scientifically worthy endeavor to relieve the next and succeeding generations of that part of the burden of dependency which is preventable.

Psychiatrists have a certain popular misconception to correct. The public is irked by the burden of dependency. Avoidable dependency is almost wholly due to intelligence defects, preventable largely in one generation and for those that follow, and to character deviations, partly remediable in this generation. These two classes are included among those popularly called feebleminded; but the popular mental picture is that of the idiot and imbecile. Our field of remediable cases includes none of these, of course, but is made up of those of a mental level no lower than that of moronity. The public has a right to know that a part of what has been hitherto called feeblemindedness, and not incorrectly so named, is in the higher grades preventable and remediable.

When it is understood that a considerable fraction of our dependents are really improvable in behavior and salvable by character training, the public will be ready to provide for such training. The cases to be included do not appear at hospital clinics and do not generally regard themselves as cases; but such could be found in numbers by the field workers who would form an essential part of such a psychiatric organization as would be competent in each state or municipality to deal with this class. The two mentally hygienic purposes to be realized then are (1) to deny parenthood to the unfit and (2) to assist our high-grade dependents to build a more worthy character and become economically successful. Provision for these measures would also adjust that rather anomalous position in which society is still placed when intellectually incompetent persons are sentenced to a reformatory or other penal institution without a psychiatric examination. The question now being worked out in some states, e. g., Ohio, of maintaining a central clearing house of entrants to public custodial institutions would be automatically taken care of also, since the state psychiatric staff would perform that function.

APPENDIX

Two abstracts of cases are submitted, illustrative of the wider-angled presentation form of summation, enabled by the recognition of character as a categorical entity in mentality study.

CASE NO. —

H. is a fairly well developed girl of 15.9 years, definitely ascertained. She consistently maintained that her age was thirteen. Skin shows fine superficial acne and lacks good color. Her mental attitude is rather listless and lacking in spontaneity and responsiveness. Of her father she apparently knows nothing. Of her mother she reports her death when H. was three. Of her siblings and collateral relatives she apparently knows nothing and conveys the impression that she lacks interest. She was cared for as a state charge or in a family in childhood till she began school at about the age of seven. In school in Oakland she repeated no grades but was regularly advanced till she attended a high school for a year. She left school on her own initiative to begin housework, having worked for her board while attending school. During this experience she was discharged for theft.

This fact she was very slow to admit and would have allowed an incorrect reason for this change of residence to be recorded. No place was held by her more than a few days after this, and she became dependent on the Maine Children's Home Society, at Augusta, an institution that had several times placed her, apparently favorably.

Menstruation began at the age of eleven. She denies transgression, but admits understanding the meaning of sex intercourse. She admits being out evenings with girls and boys and that sometimes a boy and girl went off by themselves, but adds that she never did this.

On the day of the examination it is learned from her guardian that she begged for permission to answer a letter to a boy in Waterville, ten miles away, saying she must answer it; but she would give no valid reason. Refused, she canvassed the possibility of walking to Waterville to see him. The snow of an exceptionally severe winter was piled impassably high. Then she sought permission to write to a girl friend whose reputation in sex matters is bad. This being reluctantly given on her representation that she *must* write her; she apparently prepared the letter. As the rural delivery man appeared she slipped out to the country road through the deep snow and gave him a letter reporting on her return that she had posted the letter to her girl friend. This roused suspicion and her effects were searched revealing an unfinished letter to the girl. In the letter was found about a foot of gold chain recognized by the guardian as her own (the guardian's).

Under H.'s pillow that morning had been found too, a piece of black lace that the guardian identified as her own (the guardian's) and which must have been taken from the depths of a trunk in the attic to which H. was not supposed to have access. Furthermore, a dime which H. had seen left in a vest had been missed. When inquiry was made of H. anent these items she vehemently denied one after the other, "Honest to God" she had not seen the dime, knew naught of the lace, etc.

When tested she showed very good scholastic ability, computing interest mentally. Her general information was rather remarkably good. She could attend well and showed quick penetration and grasp and readily drew correct academic conclusions; but she became silent whenever a disagreeable admission was called for. Her reluctant admission could be at length elicited; but not so long as she could see any escape by evasion. She volunteered nothing except in excuse or extenuation, e.g., after several specific admissions of theft had been won from her she volunteered "I can't help stealing," and again, "I steal things I don't want." "Have you ever been tempted to steal something when you have decided not to steal and have walked away leaving it?" "Yes I have." "Well, does not that show that you can avoid stealing when you really try your best?" She hesitated long before answering in the affirmative, meanwhile admitting and showing she understood the logic of the situation. "Would you not blame anyone who steals from you?" "Yes." "Does not the law hold anyone who steals punishable?" "Yes." "Well, aren't you to blame if you steal then?" Again she very reluctantly admitted her responsibility. At one point she volunteered that she never had stolen money. When she was told that the examiner probably ought not to believe that, as it was so unlikely that anyone who had stolen as she had done would refrain from taking money, she at length admitted she could not blame the examiner for declining to believe that statement. The distinction between telling her she could not be believed in a certain statement and calling her a liar was appreciated and admitted readily.

She resisted the suggestion for sometime that her life was one of failure more than success because of her thefts and lying, but at length admitted it. Then she resisted the suggestion that she could change all that and live a happy and successful life if she would try hard enough. No satisfactory reaction could be elicited to this, no smile or hopeful attitude, though at the time this suggestion was made her admissions were all in, her fencing had ceased and she was quite at ease and thinking clearly on the subjects suggested.

Findings:

Mental disease: none.

Intelligence: mental age level, 15; I. Q., 1.; category, normal or adult. Capacity for abstract reasoning poor even for her age, but when stimulated her conclusions are valid. Foresight and planning are very illy developed.

Character rectitude or deviations: principally in the emotional sphere and exhibited in habitual theft and lying. Reactions to altruistic, patriotic and filial regard stimuli lack development. Reaction to considerations of self-interest is weak. Insight is poor. Impulse is the principal guide to action and capacity, for self-denial is small. Voluntary control of expression is habitually that of dissembling and, impulsive egotistic *sang froid* is consistently maintained.

Sociologic maladjustment: criminal tendency, dependent child.

Case No. —

American-born, age 21–3, of naturalized German parentage. Attended Bridgeport schools from 7 to 15, more than half time, repeating four grades, one of them twice. Was out for sickness; heart trouble of which he has none now. Truancy not a large factor. Father died of paralysis five or six years ago. Mother is living. She was at a sanitorium three months on account of being "run down." Lost her memory and could not care for her household. History of collaterals is negative for institution residence and dependency. Sister is a widow at home with mother and brother who is a carpenter—a family with no margin of safety.

S. was married soon after the age of twenty-one to an imbecile after having been balked in several attempts. He admits gonorrhea while in the army four months whence he was honorably discharged as mentally unfit. He handled fractions well and denominate numbers and knew how to attack simple interest. His general information was good. His answers were prompt and though at times tending to be flippant and evasive he readily adjusted his attitude on a warning. He uses tobacco, but denies the use of drugs and alcoholics. Physically, he is well nourished but musculature is soft. There is a mild conjunctivitis. Forehead is both low and narrow; teeth are crowded and irregular. Clothes are dirty. House is poorly furnished and is unpainted and illy repaired, but is swept and fairly orderly. S. was found sitting in house idle with wife and her eight-year-old sister. He resisted the suggestion that these are remarkably favorable times for working men and would have loquaciously taken over the interview at this point, at others also. His chief interest was in excusing, exculpating and inveighing against those who extended no help and sympathy. He claimed to have walked three miles and back in an unsuccessful hunt for work on the preceding day. He resisted the suggestion that he made a mistake in leaving school and neglecting a trade, also the suggestion that he would have done better to stick to the $2.50 a day he was getting before he joined the army. A search for motives for joining the army elicited no suggestion of anything more worthy than self-interest and the stress was on his feeling "he wanted to go." To the suggestion that he now had the responsibility and burden of a wife, he again took the superficial view, saying she was as well off as before her marriage. He was a little disturbed but not resentful that the army examiners had found him "deficient mentally." Denies arrests.

Mental disease: none.

Intelligence: mental age level, 15; I. Q., .90; category, adult, but judgment is poor.

Character rectitude or deviations: shows various anomalies, e.g., lack of action for self-support, due in part to lack of appreciation of the worthy motives for so doing. Capacity for self-denial is small. Altruism and patriotism are not in evidence. Ambition is undeveloped. Love of ease and gratification are too ascendent.

Sociologic maladjustment: potential dependent.

NOTES AND COMMENTS

Illinois

The Department of Public Welfare, in conjunction with the Board of County Commissioners of Cook County, opened the Juvenile Psychopathic Institute at the Cook County Psychopathic Hospital, on December 18, 1917. A voluntary consulting service has been inaugurated designed to offer free consultation with physicians, psychiatrists, psychologists, social workers, probation officers, judges, occupation and employment workers and others, to all who may apply.

The work of the service includes (1) examination for feeblemindedness, (2) examination of incorrigible or truant cases, or those showing other signs of misconduct likely to prove dangerous to themselves or to the community, (3) after care and follow-up work of juveniles who are on probation, or otherwise assigned to the Institute by the court, or who are on parole from the State Schools of St. Charles and Geneva, and the State Reformatory at Pontiac. This branch of the work will be carried out in co-operation with the state parole officers, the probation officers of the various courts, and the social agencies of Cook County.

Two wards have been set aside at the Psychopathic Hospital for the institutional observation and treatment of juvenile psychopathic individuals. These wards contain twelve beds each, one ward for boys and the other for girls. No child may be kept longer than ten days. Children may be admitted voluntarily, at the request of parents or guardians, through court order of the County or Juvenile Court, and by transfer from the Juvenile Detention Home.

The work of the Institute includes medical and psychiatrical examination, psychological testing and social investigation. The work is conducted as an out-patient department, applicants coming at will or by appointment, and receiving a preliminary examination. When more extended examination is necessary, or when observation is desirable, the children are admitted to the wards set aside for this purpose.

Maine

The Augusta State Hospital is about to establish in Portland a clinic for mental and nervous disorders. Suitable accommodations have been secured in the City Hall, and the clinic will be held once each week from 10 a. m. until 4 p. m., on Wednesdays.

The sole object of the clinic is the conservation of mental health, and it is hoped that physicians will refer their mental cases for consultation, that organized agencies having mental or difficult cases will avail themselves of it, and that all persons feeling the need of advice or examination will feel free to present themselves.

Massachusetts

Chapter 142 of the Acts of 1918, approved April 12, and effective upon its passage, providing for the temporary care of persons in the military or naval service of this country suffering from mental disease, reads as follows:

"Section 1. The superintendent of any state hospital for the care, treatment or observation of the insane, and the McLean Hospital, may receive for care and treatment any person in the military or naval service of the United States who is suffering from mental disease and cannot properly be cared for at the army post or naval station or hospital where he is stationed or happens to be, upon the written application of the medical officer in charge of such post, station or hospital, who shall make a full statement of the case in such form as may be prescribed by the commission on mental diseases. Unless otherwise ordered by the proper military or naval authority, persons received into a hospital under the provisions of this act may be detained therein for a period not exceeding sixty days, except that further detention, if necessary, may be authorized by the commission on mental diseases.

"Section 2. The commission on mental diseases is hereby authorized to make contracts with the federal government relative to the support of persons received and cared for under the provisions of this act on such terms as may be agreed upon."

New Jersey

A new board of Charities and Corrections has been created under Chapter 147, Laws of 1918. This measure is the direct result of the recommendations made by the Prison Inquiry Commission and the Charities Inquiry Commission appointed by the Governor to investigate the institutions in the state.

The board is to have control over the charitable and penal institutions of the state, and is charged with establishing broad lines of policy for their development. It is also to have supervision, with the right to visit and inspect, all county, municipal and private institutions receiving state aid. This board is authorized to appoint a commissioner to be its chief executive, whose salary is not to exceed $10,000 a year. The board also has the power to create a division of medicine and psychiatry, one of education, one of labor and agriculture, one of statistics, one of parole, one of food and dietetics, and any such other divisions as it may deem necessary. This law among other provisions states that any person suffering from insanity or alleged to be insane shall not be committed to or confined in any unlicensed private institution in the state for the care and treatment of the insane.

This law also makes provision for the admission and commitment of the insane epileptic, tuberculous and feebleminded to the several institutions devoted to their care.

The following provision for voluntary admission to hospitals for the insane may be of particular interest:

"Any person resident in this state believing himself about to become insane or in danger of losing his reason, and being desirous of obtaining treatment for the betterment of his mental condition, may be admitted to any public institution for the care and treatment of the insane in this state by filing with the chief executive officer thereof, at or before his admission, an application in writing to be approved and furnished by the board of managers or the board of chosen freeholders, as the case may be, setting forth his name, place or places of residence, for a period of ten years preceding such application, and a full statement of his financial ability to support himself, or the financial ability of the person or persons chargeable by law with his support, together with such other information as may be required on the forms approved and furnished as aforesaid. It shall be the duty of the chief executive officer to forward forthwith a certified copy of such application to the commissioner in lunacy of the county from which such patient is admitted, who shall investigate the matter of legal settlement and indigence of such patient, and the person or persons chargeable with his support, and report the facts to the proper judicial officer of such county, who shall make a legal finding as to the legal settlement and the financial ability of the patient or the person or persons chargeable with his support as aforesaid, and shall have the right to make an order for the payment of the whole or any part of the costs and expense of the care and maintenance of such patient, as in the case of involuntary commitments. Such finding shall be filed in the same manner as final orders of commitment are filed."

The law also provides that "if any person in confinement under commitment, indictment or sentence, or under any process, shall appear to be insane, epileptic, imbecile, or feebleminded, the justice of the Supreme Court presiding in the courts of the county in which such person is confined, or judge of the Court of Common Pleas of said county, may, upon presentation to him of the application and certificates hereinabove provided, institute an inquiry and take proofs as to the mental or physical condition and legal settlement of said person in the manner and form hereinbefore provided, pending which inquiry such person may be temporarily confined in an appropriate public institution in this state, upon an order of such justice or judge; and if said justice or judge shall determine that said person is insane, epileptic, imbecile or feebleminded, he shall order that said person be removed from imprisonment, and that he be confined in one of the institutions for the care and treatment of such persons owned by the State of New Jersey, or if said justice or judge shall deem it expedient, in an institution for the care and treatment of such persons owned by one of the counties of this state, until said person is cured or removed or discharged according to the law."

New York

The New York State Prison Commission appointed at its last monthly meeting a Committee on Mental Disease and Delinquency which has begun inquiries to enable it to outline legislation for the state to provide for psychiatric facilities for the state penal and reformatory institutions. This action was taken following a resolution adopted by the Commission endorsing psychiatric work among prisoners.

At a meeting of the Superintendent of Prisons of the State of New York with the prison wardens and physicians, on July 12, 1918, a committee was appointed to outline measures for continuing the Psychiatric Clinic at Sing Sing Prison, and for extending the work to the other prisons of the state.

In accordance with chapter 197, which became a law April 13, 1918, Dr. Walter B. James of New York City has been appointed Chairman of the State Commission on Feebleminded. The men who will serve with Dr. James are the Fiscal Supervisor of State Charities and the Secretary of the State Board of Charities.

The duties of the commission are as follows:

1. To administer the law in relation to the custody, care and treatment of the feebleminded.
2. To take a census of all feebleminded.
3. To provide and keep a record of all feebleminded persons in the state, and to provide accommodations for all that require care and treatment in a suitable institution.
4. To prepare and recommend to the legislature by February 1, 1919, a commitment law for the feebleminded.
5. To provide for establishment and operation of clinics for the examination and observation of feebleminded persons.
6. To provide for the establishment of farm and industrial colonies.
7. To make regulations for the reception, care, training, parole and discharge of inmates of institutions for the feebleminded.
8. To direct the transfer of inmates from one institution to another.
9. To make a report annually to the legislature, giving an account of its proceedings, facts necessary for the information of the legislature, a statement of the capacity of each institution and an estimate of the number of additional beds required for the ensuing year.

The act carries an appropriation of $25,000 and became effective July 1, 1918.

Chapter 639, which became a law May 13, 1918, creates a department of narcotic drug control, the head of which is the commissioner of narcotic drug control. He is appointed by the governor, with the advice and consent of the senate, for a term of six years, at a salary of $6,000 a year. He may appoint three deputy commissioners at a salary of $3,500 each, and also a secretary, who shall also act as financial clerk, to receive $3,000 a year. The commissioner may also appoint counsel and other employees that are needed. The department is to regulate the prescribing and dispensing of narcotic drugs. This law also provides for the commitment of addicts, and for their voluntary admission for hospital treatment. For the carrying out of the provisions of this act, the sum of $27,400 is appropriated, for the period of eight months ending June 30, 1919.

In September, 1916, a joint legislative committee was appointed, in accordance with a resolution passed in April, 1916, to investigate the laws in relation to the distribution and sale of narcotic drugs. This committee reported to the legislature in February, 1917, and at that time requested an extension of time to make a more complete investigation. This extension was granted, and the committee again reported in March, 1918. The law creating a department of narcotic drug control is the outcome of the study and recommendations of this committee.

Chapter 342, laws of 1918, provides for the establishment of a bureau of venereal diseases in the state department of health, and appropriates $30,000 for carrying into effect the provisions of the act.

The bureau is authorized to buy, manufacture and dispense, under conditions prescribed by the state commissioner of health, remedies for the treatment of these diseases, to examine specimens submitted, to make all necessary tests, to provide and distribute literature and to use such other means as seem desirable for the instruction of the public and the suppression and cure of venereal diseases.

South Carolina

Act 398, approved by the Governor on February 12, 1918, provides for the establishment of the State Training School for the Feebleminded. This institution is to be under the supervision of the Board of Regents of the State Hospital for the Insane, but is to be entirely separate from the hospital both in location and management. The Board is authorized to appoint an advisory committee of three women whose duties shall be to visit the institution at least quarterly and to advise with the Board as to the management of the school.

In accordance with the provisions of this act, feebleminded persons may be (a) admitted or (b) committed to the institution. "In granting the applications for admission, or in accepting the commitments, of feebleminded persons to the said Training School, the Board of Regents or the Superintendent, acting with such discretionary powers as are given him by this Act and by the Board of Regents, shall observe the following conditions: (1) No decree of any Court having jurisdiction under this Act, committing any feebleminded person to the said Training School, shall be binding upon the said Board of Regents until accepted by them. (2) Preference may be given to women of child-bearing age, and to the more trainable boys, girls and young men. (3) The Board of Regents shall prevent undue crowding of inmates in the said Training School."

"Applications for the admission of feebleminded persons shall be made to the Board of Regents of the State Training School in the following manner: First, by the father or mother, if the father and mother are living together; second, if the father and mother are not living together, then by the one having the custody of the child; third, by a guardian duly appointed; fourth, by the superintendent of any county almshouse, or by the person having the management of any orphanage or other institution where children are cared for; fifth, by the County Commissioners of any county or the County Supervisor in those counties which have no County Commissioners. In items three, four and five of the above, the consent of the parents is not required. It is further enacted that all applications for admission shall be submitted by the said Board of Regents to the State Board of Charities and Corrections before being granted. Thereupon, the State Board of Charities and Corrections shall investigate the application and report their findings with their recommendations to the Board of Regents of the State Training School for the Feebleminded. The said Board of Regents shall then, in accordance with such rules as they may make, determine which of these applications for admission shall be granted and in what order."

The procedure in the case of commitment is as follows:

A relative, guardian or any reputable citizen of the state may file with the Judge of the Probate Court or with the Clerk of the Circuit Court, a petition in writing, setting forth that the person is feebleminded, the facts and circumstances of the social conditions, or other causes, making it unsafe for the community for him to be at large without supervision, control or care; also the name and residence of the person caring for him, if any, and of at least one person, if any there be, legally chargeable for his support, and also, if known, the names and residences of the parents or guardians.

The hearing on the petition is by the court and a commission appointed by the court consisting of two qualified physicians, or one qualified physician and one qualified psychologist, residents of the state, appointed by the judge. The commission is to examine the person, and upon conclusion of the hearing and examination, the commission shall file with the court a report setting forth their conclusions and recommendations.

If the court finds that the person is not feebleminded he shall be discharged. If he is found to be feebleminded he shall be sent to the School provided for in this act.

For carrying out the provision of this act, $60,000 is appropriated.

Buenos Aires

A report of the state hospital for the insane, which covers a period of twenty-seven years, states that alcohol was responsible for the insanity in 39.6 per cent of the 28,035 patients during that period.

THE CANADIAN NATIONAL COMMITTEE FOR MENTAL HYGIENE

The Canadian National Committee for Mental Hygiene, the second national agency of this kind to be established, was organized at Ottawa, April 26, 1918. In regard to its organization, Mrs. Colin K. Russel, in the June number of *The Canadian Medical Association Journal* says:

"Though much special work along many of these lines has been done in various individual groups in Canada, it is to Dr. Clarence M. Hincks, of Toronto University, that we owe the co-ordination of effort which has resulted in our new Canadian National Committee for Mental Hygiene. His was the vision which, having a keen appreciation of our needs in Canada, combined a power of organization with unusual energy and enthusiasm. Learning of the work of the National Committee of the United States, he set to work to rouse the public interest in the need for such a work in Canada."

Following is an abstract of the proceedings of the founding meeting of the Canadian National Committee for Mental Hygiene:

The business transacted at the founding meeting consisted of the adoption of a constitution, the election of officers, and the outlining of a programme for immediate work. In connection with the latter, Mr. Clifford W. Beers was called upon to give an account of the work of the (American) National Committee for Mental Hygiene, of which he is Secretary. Mr. Beers gave interesting information with regard to surveys conducted by the National Committee, and said that through such work improvement in the care and treatment of the insane had followed. He also spoke of the studies that are now being conducted at Sing Sing Prison, and stated that investigations into the psychopathology of crime would probably have a far-reaching influence in reforming methods of treating criminals. Mr. Beers referred to the work of the Committee in connection with the problem of feeblemindedness. He then emphasized the valuable war work that was being conducted, and pointed out that the National Committee had been instrumental in establishing a mental examination of drafted men in the American Army, and that on account of this step 15,000 men had been rejected because of mental and nervous disability. This would result, he said, in a tremendous financial saving to the United States and would be of incalculable value in maintaining a high grade of efficiency and morale in the army.

With the work of the (American) National Committee for Mental Hygiene in mind, and after considering pressing needs in Canada, the following programme of work was undertaken for the ensuing year:

1. *War Work.* A careful study of the problem of mental and nervous disease in the Canadian Army will be undertaken, and the way in which mental and nervous cases have been treated in England, France, and the United States will be carefully considered. Based upon these findings it is proposed to present recommendations to the proper authorities. In addition, the Canadian Committee will endeavor to assist the military authorities in finding personnel for military mental hygiene work, and will arrange, through Canadian universities, to have special courses of instruction provided for prospective workers in this field.

2. *Immigration.* It is proposed that the Canadian National Committee should make a comprehensive study of the problem of immigration in Canada, should advise itself concerning what has been done in other countries, particularly the United States, to exclude the mentally abnormal immigrant, and when such studies are concluded should make recommendations to the proper governmental authorities. This programme was adopted because it was known that probably 50 per cent of all the feebleminded and insane in Canada were foreign-born, and it was quite evident that the Federal Government at Ottawa had not in the past made satisfactory provision for the exclusion from the Dominion of mentally abnormal immigrants.

3. *Statistics.* The Canadian Committee will begin a statistical study of the treatment and care of the insane and feebleminded in the various provinces. Included in this department of work will be the collection of facts relating to the legal basis of state care; the history and present status of state care; the economics of state care; facts concerning state administration, supervision, and inspection; facts concerning state institutions for the feebleminded and insane; facts concerning commitment, discharge, and parole; social service in mental cases; psychiatry in medical schools, etc.

4. *Library.* The Committee will establish a library on mental hygiene, and will specialize, during the first year, on literature relating to war psychoses and neuroses, and immigration. It is hoped that the library will perform a useful function in collecting and distributing material in answer to requests for literature and information, in supplying material for lectures and lecture courses, exhibits, and general propaganda, and in supplying bilibographies for distribution.

5. *Research.* The Committee will endeavor to arrange for special investigations to be made in various parts of the Dominion. It was suggested that among other studies an investigation into the psychopathology of juvenile delinquency and prostitution would be exceedingly useful.

6. *Propaganda.* Arrangements will be made for lectures on mental hygiene in various centres of the Dominion during the coming year. In such cities as Montreal and Toronto several public meetings addressed by eminent American authorities will be held. In addition, members of the Canadian Committee will give addresses on mental hygiene from time to time, and pamphlets on the subject will be distributed.

7. *Contemplated activities that will be postponed until the second year.* (a) Establishment of provincial and municipal societies for mental hygiene. (b) Surveys of hospitals for the insane.

Before the meeting adjourned it was announced that $50,000 had already been subscribed for the work of the Committee, and the following resolutions were passed:

That whereas the (American) National Committee for Mental Hygiene has manifested a keen interest in the organization of the Canadian National Committee for Mental Hygiene by sending to Canada, its secretary, Mr. Clifford W. Beers, and by making a presentation of many copies of his book, "A Mind That Found Itself," that therefore this Committee express to the (American) National Committee its hearty appreciation; and that, whereas Mr. Clifford W. Beers has, through his splendid efforts during his visits to Toronto, Ottawa, Montreal, and Quebec, on behalf of the Canadian National Committee for Mental Hygiene, rendered the most valuable assistance in facilitating organization, stimulating interest in mental hygiene, and in securing financial support, that therefore this Committee place itself on record as acknowledging with the sincerest appreciation the help which he has given.

The following are the officers of the Canadian National Committee for Mental Hygiene:

Patron: His Excellency the Duke of Devonshire, Governor-General of Canada.

Patroness: Her Excellency the Duchess of Devonshire.

President: Lieut. Col. Charles F. Martin, M.D., Montreal.

Vice presidents: Lord Shaughnessy, Montreal; Sir Vincent Meredith, Montreal; Sir Lomer Gouin, Premier of Quebec; Sir Robert Falconer, Toronto; Sir William Peterson, Montreal.

Treasurer: Sir George Burn, Ottawa.

Executive Committee: Lieut. Col. Colin K. Russel, Montreal, Chairman; Dr. Peter H. Bryce, Ottawa; Prof. J. A. Dale, Montreal; Dr. C. J. O. Hastings, Toronto; Dr. W. H. Hattie, Halifax; Lieut. Col. Vincent Massey, Toronto; Major J. D. Page, Quebec; Dr. C. A. Porteous, Montreal; Prof. Peter Sandiford, Toronto; Lieut. Col. Charles F. Martin, Montreal.

Executive Officers: Dr. C. K. Clarke, Toronto, Medical Director; Dr. C. M. Hincks, Toronto, Associate Medical Director and Secretary.

In addition to the officers, the following representative men and women of the Dominion are also members:

Hon. George E. Amyot, Quebec
R. B. Angus, Montreal
Lord Atholstan, Montreal
Adam Ballantyne, Toronto
Capt. Gordon Bates, Toronto
E. W. Beatty, Montreal
Col. H. S. Birkett, Montreal
W. M. Birks, Montreal
Dr. A. D. Blackader, Montreal
Dr. Edward A. Bott, Toronto

His Honour Lieut. Governor Brett, Edmonton
Dr. Horace L. Brittain, Toronto
Dr. Brochu, Quebec
Dr. Allan Brown, Toronto
Dr. T. J. W. Burgess, Montreal
J. Burstall, Quebec
Hon. Thomas Chapais, Quebec
Dr. W. H. Chipman, Montreal
Mrs. P. D. Crerar, Hamilton
Dr. Winnifred Cullis, Toronto
Dr. F. E. Devlin, Montreal
Mrs. Arthur Drummond, Montreal
Mrs. D. A. Dunlap, Toronto
Lady Eaton, Toronto
Major J. G. Fitzgerald, Toronto
Mrs. J. G. Fitzgerald, Toronto
Sir Joseph Flavelle, Toronto
Mrs. W. L. Grant, Toronto
W. D. Gwynne, Toronto
Chief Justice Harvey, Edmonton
Dr. Goldwin Howland, Toronto
Mrs. A. M. Huestis, Toronto
Miss Hurlblatt, Montreal
Lady Kingsmill, Ottawa
Dr. Lachapelle, Montreal
Mrs. J. B. Laidlaw, Toronto
Sir Richard Lake, Regina
Judge Langelier, Quebec
Sir James Lougheed, Calgary
Dr. Helen MacMurchy, Toronto
C. A. Magrath, Ottawa
Hon. W. M. Martin, Premier of Saskatchewan
J. M. McCarthy, Quebec
J. O. McCarthy, Toronto
Mrs. Nellie McClung, Edmonton
Dr. R. E. McKechnie, Vancouver
Francis McLennan, Quebec
Mrs. McLimont, Quebec
Mrs. W. B. Meikle, Toronto
Lady Meredith, Montreal
W. R. Miller, Montreal
F. W. Molson, Montreal
Dr. Gordon Mundie, Montreal
Judge E. F. Murphy, Edmonton
President W. E. Murray, Saskatoon
W. F. Nickle, M.P., Kingston, Ontario
Sir Edmund Osler, Toronto
Dr. E. J. Pratt, Toronto
Sir William Price, Quebec
Rev. W. M. H. Quartermaine, Renfrew, Ontario
Miss Helen Reid, Montreal
Prof. R. G. Revell, Edmonton
Dr. Armour Robertson, Montreal
Bishop Roper, Ottawa
Frank W. Ross, Quebec
John Theodore Ross, Quebec
Mrs. Colin K. Russel, Montreal
Dr. Francis J. Shepherd, Montreal
Mrs. Adam Shortt, Ottawa
Mrs. Sidney Small, Toronto
Hon. George P. Smith, Edmonton
Prof. W. G. Smith, Toronto
Hon. Charles M. Stewart, Calgary
Rev. Dr. Symonds, Montreal
Madame Jules A. Tessier, Quebec
Hon. R. S. Thornton, Winnipeg
Hon. A. Turgeon, Quebec
Dr. von Eberts, Montreal
Miss Grace T. Walker, Toronto
Mrs. H. D. Warren, Toronto
Dr. F. F. Wesbrook, Vancouver
Hon. Smeaton White, Montreal
T. H. Wills, Hamilton
Capt. O. C. J. Withrow, Toronto
Major H. P. Wright, Montreal

TRAINING SCHOOL OF PSYCHIATRIC SOCIAL WORK

The opening of the Training School of Psychiatric Social Work at Smith College, Northampton, Massachusetts, on July 8 was an event of much importance in the mental hygiene movement. That the education of lay workers for the care of nervous and mental cases should have been undertaken by one of our distinguished colleges is significant of a growing change in public sentiment toward mental disease precipitated by sympathy for the so-called "shell shock" cases of the war. That the course should be given under the auspices of the National Committee for Mental Hygiene through a committee of eminent psychiatrists is significant of the increasing disposition of physicians to consider the social involvements of mental disorders. The war emergency has focused influences that were already active. For several years, there has been a demand that could not be met for psychiatric social workers in civilian work, but no provision for training existed except apprenticeship courses such as the Department of Social Service of the Boston Psychopathic Hospital offered. The Director of this hospital, Dr. E. E. Southard, foreseeing an increased war demand for social workers so trained, secured by means of an appropriation from the Permanent Charity Fund of the Boston Safe Deposit Company the release of the Chief of Social Service, Miss Mary C. Jarrett, on part time for organization of war emergency courses. At the same time the National Committee for Mental Hygiene, facing the problems involved in the rehabilitation of soldiers returned suffering from nervous and mental disorders, was convinced of the need of training lay workers to assist physicians in the care of neuro-psychiatric cases, and a committee of which Dr. Southard was chairman was appointed to take up the matter. Meanwhile the probable demand for trained workers in this field had been suggested to Dr. Neilson, President of Smith College, at that time considering several types of war work for a possible summer school. A combination of these elements resulted in the present Training School, which gives an eight months' course, eight weeks of didactic work at Smith College followed by six months of practical experience in different hospitals and organizations.

The object of the course is to prepare social workers who shall be able to perform three functions if necessary, or any one of the three that may be required; (1) to secure social history essential to medical diagnosis by interview or correspondence with informants or by interviewing patients; (2) to assist the physician in psychotherapy by such means as encouragement, explanation, re-education; (3) to promote the social adjustment of patients upon discharge from the hospital. The students will be instructed in the technique of social case work both by lecture and practice. During the summer session, they receive instruction in psychology, including mental tests; sociology, including community organization and methods of social case work; and social psychiatry, covering the general character of nervous and mental disorders and including clinics at the Northampton State Hospital. Equally important as the knowledge gained is the discipline acquired in such a training school. An eight months' course in a subject that deals with so complex a matter as human personality must be recognized to be superficial at the best. The student, however, will be drilled in the fundamental habits of mind required for further development—a professional attitude, the psychiatric point of view, adaptability, the habit of observation.

The March number of the *Public Health Journal*, Toronto, Canada, is devoted to the subject of feeblemindedness. The following articles are of special interest: "The Work of the Psychiatric Clinic of the Toronto General Hospital," C. K. Clarke, M. D.; "The Problem of the Feebleminded," Marjorie Keys; "Mentally Deficient Children," Clarence M. Hincks, M. D.; "Psychology and Public Health," W. G. Smith; "Mentally Deficient Recruits for Army Service," Capt. O. C. J. Withrow, C. A. M. C.; "Hamilton Branch of the Provincial Association for the Care of the Feebleminded," T. H. Wills.

Dr. Clarke, after briefly stating the aim of the Clinic in its establishment, and noting the enthusiastic co-operation of the city health authorities, the juvenile court, and the board of education, offers statistical material of much interest.

From April 8, 1914, to February 1, 1918, of the 3,587 patients examined, 1,249 of those diagnosed as defective came from the juvenile court. There were found to be 862 morons, 818 imbeciles and 114 idiots. Of the total number examined only 322 could be classified as "probably normal." There were 448 cases of immorality, among whom were 218 mothers of illegitimate children. Although no general routine Wassermann test was made, 225 were found to be syphilitic. At the present time every case examined has a Wassermann test.

Dr. Clarke states that recently the number of morons coming to the Clinic has greatly increased, and he strongly advocates segregation of this class before they develop criminality. Of the patients coming to the Clinic, only 45.33 per cent are Canadian. From this fact Dr. Clarke concludes that the authorities have been negligent at the ports of entry, and urges a careful mental survey of immigrants.

The author points out the close relationship between prostitution, illegitimacy, feeblemindedness and venereal diseases, and recommends the segregation of defective prostitutes as an effective measure in helping to deal with the question of the increase of venereal disease.

THE VENEREAL DISEASE PREVENTION ACT OF ONTARIO, CANADA

"The following is a synopsis of an Act recently passed by the Legislature of the Province of Ontario with the purpose of controlling venereal diseases.

"The Act provides that any person under arrest may, if the medical officer of health believes that the person is infected with venereal disease, be required to undergo an examination in order to ascertain if he is, or is not, infected with this disease, which by the Act includes gonorrhoea, syphilis and chancroid. If the person so examined is found to be infected he may be detained and treated. Physicians in medical charge of gaols and other places of detention are required to report within twenty-four hours, any persons confined who may be found to be infected.

"If a medical officer of health has credible information that any person is suffering from venereal disease the officer may require such person to be examined, and if the person is infected the officer may take steps requiring satisfactory treatment.

"In order to prevent unjust action against a physician who makes an examination or report in respect to such cases, it is provided that such action can only be brought with the consent of the Provincial Board of Health.

"Provision is made for right of entry to a house or premises by the medical officer of health or his deputy in the daytime for the purpose of inquiry or examination in respect to such cases. This provision is identical with the one in force in respect to other communicable diseases.

"Hospitals designated by the board are required to provide facilities for treatment.

"No one but a legally qualified physician is allowed to attend upon or prescribe for or supply or offer to supply any drug, medicine, appliance or treatment to or for a person suffering from venereal disease or for the purpose of the alleviation or cure of such disease; the only exception to this being that a qualified chemist may fill the prescription of a physician for such purposes. The penalty for infringement of this provision is $100 to $500. A similar penalty is provided against advertising in a newspaper, pamphlet or other periodical, any remedy or cure for these diseases. This penalty is also provided for anyone knowingly infecting any person with venereal disease.

"Anyone making statements to the effect that a person has one or other of these diseases except in case of disclosures made in good faith to a medical officer of health or physician in consultation is liable to a penalty of $200.

"Provision is made with the object of maintaining secrecy in respect to cases of this nature by those who have the administration of the Act.

"The most important feature of the bill lies, however, in the powers given the Provincial Board to make regulations in regard to the *forms* and *notices* to be used in the administration of the Act, the *remedies* to be used, the *course of conduct* of the patient, the *distribution of information* concerning these diseases, the *regulation of treatment* in hospitals, etc., *preventing* infection, *reporting of cases* by serial number, *notices* and *placards* in public places, *imposing penalties* for infringement of regulations, *procedure* in appeals which may be made as a finality to the board and the *method and extent of examination* of persons.

"The board is given power to manufacture and distribute remedies free or otherwise to local boards of health, physicians and hospitals.

"Any expense in carrying out the provisions of the act may be incurred by the medical officer of health or local board, and such expense must be met by the municipality. The regulations under the Act are now in course of preparation and the law goes into effect July 1, 1918.

"While the effect of this law, which is a fairly drastic one, can scarcely be foreseen, it is reasonable to regard it as a decided step in advance.

The restriction of practice in these diseases to qualified physicians and the prohibition of the advertising of quack remedies will, it is hoped, do much to eliminate the baneful effects of treatment by druggists and quacks, who not only do no good, but usually do a lasting injury to the victims of these diseases, not only by leaving them uncured, but in addition, by giving them a false sense of security, which allows of the transmission of disease to innocent parties. Reporting of the names of those infected, which does not seem to have worked well in practice elsewhere is not sanctioned by the Act, but reporting by number is required."—John W. S. McCullough, M. D., D. P. H., Chief Officer of Health, in the *Public Health Journal*, Toronto, May, 1918.

THE NON-RESTRAINT SYSTEM IN THE INSANE WARDS OF NAGASAKI HOSPITAL, JAPAN

An article by Dr. Noboru Ishida, Professor of Psychiatry, Nagasaki Medical College, and Chief Alienist of the Prefectural Nagasaki Hospital, Nagasaki, Japan, which appeared in the June number of *The Modern Hospital*, gives an acount of the care of the insane in the special wards for their treatment in this general hospital. Dr. Ishida emphasizes their system of non-restraint and its benefits. The article is well illustrated.

In 1913 a small building containing 20 beds for mental cases was constructed at this hospital. This building has no guarded windows and no locked doors. A patient upon admission must have a bath for purposes of cleanliness before he is conducted to his room, and if necessary he is given a continuous bath. There are five rooms for patients, three of which contain six beds each. Each patient has an attendant, and the patients are not left to themselves. In addition to the rooms for the patients, there are a dispensary, a laboratory, a small green-house, and rooms for physicians and nurses.

Dr. Ishida states that there has been no suicide in the building since its opening, and that the number of suicidal attempts has gradually diminished. In the first year fifteen patients attempted suicide, four in the second year, and three in the third year, although in both the second and third years there were twice as many patients as in the first year.

The following extract from the July number of *The Modern Hospital* in regard to Dr. Ishida may be of interest:

"Dr. Noboru Ishida, author of the article on "The Non-Restraint System in the Insane Wards of Nagasaki Hospital," published last month, was elected an honorary member of the American Medico-Psychological Association at its recent meeting in Chicago. Dr. Ishida intends to establish communication between the American Medico-Psychological Association and the similar society existing in Japan. Readers of Dr. Ishida's article in *The Modern Hospital* will be interested to know that Dr. Ishida is the author of the most popular text-book on psychiatry used in Japan, which has gone through seven editions and is about to be issued in an eighth edition. Dr. Ishida says that his advanced ideas in regard to non-restraint of insane patients were at first much opposed by government officials, whose respect for precedent caused them to throw many obstacles in his way. He now finds no difficulty in extending the application of the non-restraint principle. The two features of American psychiatric hospitals which particularly impress themselves on Dr. Ishida are their great size and complete equipment and the sympathetic understanding of the insane shown in their treatment."

War and the Woman's College

Professor Grace A. Hubbard, in the *New Republic* for July 6, reviews the kinds of war work undertaken by the various colleges for women: The Smith Reconstruction Unit, the Vassar Training School for Nurses, the Bryn-Mawr Service Corps, the Barnard Agricultural Unit, the Mt. Holyoke summer course to prepare leaders to .look after the health of women in industry, the Bryn Mawr summer course to train leaders for industrial plans. Concerning the summer course at Smith for the preparedness of psychiatric social workers, Professor Hubbard writes:

"Smith College, while not a pioneer in the work it is to initiate this summer, is about to launch an experiment that is perhaps more of a hazard than any of these others because the field in which it is to work is itself in its infancy. Smith is to have a training school in psychiatric social work. It is to be conducted in conjunction with the Boston Psychopathic Hospital under a subcommittee of the National Committee for Mental Hygiene. This subcommittee is made up of four well known psychiatrists and the president of Smith College. There will be two months of lecture work at the college combined with clinical work in the hospitals of the neighborhood, and followed by six months of practical work in different hospitals that maintain a psychiatric department. Students may select hospitals near their homes if they wish. Three principal courses are offered; one in applied psychology, one in sociology and one in social case methods. This school is for graduates, but also for others that have had technical experience.

"'We shall be in great need of social workers who have been trained in psychiatric work,' states one of the committee. 'The work of the psychiatrist, the medical man, is not sufficient. We need a corps which will act as a sort of clearing house for all the problems confronting the shell-shocked man. We need people who have specialized not only in the usual field of social work but who have made an intensive study in psychiatry.' This specialist adds that if he can make use of a sufficient number of aids of this sort so that he may be freed to give himself to the part that he alone can do, he can treat some three hundred cases a day.

"'What in the world is psychiatry?' many asked when the plan was first proposed. Used in this connection it covers all forms of mental disorder, from the light nervous shock to insanity in a serious form. The term 'shell shock' has come to be a sort of blanket term covering all kinds of mental and nervous disorders.

"Here then is another field for women who want to help in the rehabilitation of disabled soldiers, not only in the hospital, but later, when all sorts of work will be needed in order to get men back into the social system in some normal line. It is a field suggestive of the trained nurse's, yet quite different.

"This is the immediate object of Smith's plan. But an added interest lies in the fact that almost all modern methods of dealing with civic problems, from the training of little children in the home and school, to the most complicated of provisions for the well being of citizens in all lines, are based on this type of training, or should be. The need for trained social workers will be even greater after the war, and no social problem can be adequately worked out without some knowledge of applied psychology."

MILITARY NEURO-PSYCHIATRY

Major Menas Gregory has been appointed Director of Psychiatry at the Port of Debarkation, New York. Soldiers returning from the Expeditionary Force suffering from nervous or mental disease will be examined by Major Gregory and his assistants and transported to the special hospitals provided for their treatment. Major Earl D. Bond is in charge of the psychiatric work at the Port of Debarkation, Newport News.

Major Richard H. Hutchings, Superintendent of the St. Lawrence State Hospital, Ogdensburg, New York, has been relieved from duty in the Office of the Surgeon General, Washington, to become Clinical Director of the Hospital for War Neuroses, Plattsburgh, New York.

Dr. E. E. Southard, Director of the Boston Psychopathic Hospital, has been appointed Vice Chairman of the Committee on Psychiatry of the National Research Council. Major Stewart Paton, Chairman of the Committee, is on duty at Camp Mills, Long Island, as a member of the Medical Research Board of the Aviation Section. This board is composed of eminent specialists who are engaged in studying the medical problems incident to aviation.

Captain Amos T. Baker, Psychiatrist to the Westchester (New York) County Penitentiary, formerly Director of the Psychopathic Clinic, New York City Police Headquarters, is on duty at the U. S. Disciplinary Barracks, Fort Jay, New York.

Major Edgar Fell of the Illinois State Hospital Service, formerly of the Boston Psychopathic Hospital, has been appointed Clinical Director of the psychiatric service, Base Hospital, Fort Sam Houston, Texas, Headquarters of the Southern Department.

Captain Oscar C. Wilhite, Superintendent of the Lake Geneva (Wisconsin) Sanitarium, formerly of the Kankakee (Illinois) State Hospital, has been appointed Clinical Director of the psychiatric section, U. S. Army General Hospital No. 6, Fort McPherson, Georgia.

Major Herman M. Adler, State Criminologist of Illinois, formerly Chief of Staff of the Boston Psychopathic Hospital, is on duty at the U. S. Army Disciplinary Barracks, Fort Leavenworth, Kansas, studying the disciplinary methods of the army.

Captain Ransom A. Greene, Assistant Superintendent, Monson (Massachusetts) State Hospital, has been ordered to Camp Devens as camp psychiatrist.

Captain William O. Krohn of Chicago has been ordered to Camp Travis, Texas, as camp psychiatrist.

Major George E. McPherson, Assistant Superintendent, Medfield (Massachusetts) State Hospital, is camp psychiatrist, Camp Upton, Long Island.

Captain Nathaniel H. Brush, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, is in charge of the neuro-psychiatric examinations, Medical Officers' Training Camp, Fort Oglethorpe, Georgia.

Captain T. J. Orbison, Chief of Neurological Service, Los Angeles County Hospital, formerly of the Pennsylvania state hospital service, is Clinical Director of the neuro-psychiatric service, Letterman General Hospital, San Francisco.

Major Eugene D. Bondurant, Dean of the Medical Department, University of Alabama, formerly Superintendent of the Alabama State Hospitals, is in charge of the neuro-psychiatric service, Walter Reed General Hospital, Washington, D. C.

The neuro-psychiatric service, U. S. Army General Hospital No. 2, is in charge of Major Arthur P. Herring, Secretary of the Maryland Lunacy Commission.

The Hospital for War Neuroses, Plattsburgh, New York, is under the command of Lieutenant Colonel T. D. Woodson, of the Regular Army Medical Corps.

NEURO-PSYCHIATRISTS SERVING AS CONTRACT SURGEONS

A number of well known neurologists and psychiatrists have accepted contracts for the summer and are assisting in the neuro-psychiatric work at the following camps and hospitals:

Dr. Carl D. Camp, Ann Arbor, Michigan, Camp Meade, Maryland; Dr. W. T. Kradwell, Wauwatosa, Wisconsin, Camp Dodge, Iowa; Dr.

Allen R. Dieffendorf, New Haven, Connecticut, Camp Devens, Massachusetts; Dr. A. B. Ames, Waterville, Maine, Camp Devens, Massachusetts; Dr. Arthur A. Sweeney, St. Paul, Minnesota, Camp Dodge, Iowa; Dr. Charles L. Allen, Los Angeles, California, Camp Lewis, American Lake, Washington; Dr. Leo M. Crafts, Minneapolis, Minnesota, Camp Funston, Kansas; Dr. Peter Bassoe, Dr. George W. Hall, Dr. Hugh T. Patrick, Chicago, Illinois, Fort Benjamin, Indiana and Camp Zachary Taylor, Kentucky; Dr. Swepson J. Brooks, New York City, Camp Upton, Long Island; Dr. M. A. Bliss, St. Louis, Missouri, Fort Oglethorpe, Georgia and Fort Thomas, Kentucky; Dr. C. Macfie Campbell, Baltimore, Maryland, General Hospital No. 9, Lakewood, New Jersey; Dr. Albert M. Barrett, Ann Arbor, Michigan, Dr. Smith Ely Jelliffe, New York, Dr. Walter Timme, New York, Dr. Leonard Blumgart, New York, Hospital for War Neuroses, Plattsburg Barracks, New York; Dr. James J. Putnam, Boston, Massachusetts, General Hospital No. 1, Williamsbridge, New York, and Plattsburg Barracks, New York; Dr. Robert L. Richards, Talmage, California, Vancouver Barracks and German Prison Camp, Fort Douglas, Utah; Dr. Bruce Allison, Dr. Wilmer Allison, Fort Worth, Texas, and Camp Bowie, Texas.

Development Battalions

By order of the Secretary of War, Development Battalions are being organized at each National Army, National Guard, Regular Army Divisional Camps and such other camps as the Secretary of War directs. The functions of the Development Battalions are:

a. To relieve divisions, replacement organizations, etc., of all unfit men.

b. To conduct intensive training with a view to developing unfit men for duty with combatant or noncombatant forces either within the United States or for service abroad.

c. To rid the service promptly of all men who, after thorough trial and examination, are found physically, mentally or morally incapable of performing the duties of a soldier.

Prevention of Shell Shock

Bulletin No. 4 of the War Department announcing to the Army that the Surgeon General has made special provision for the care and treatment of soldiers suffering from nervous and mental disease, states:

"The foregoing facts are announced for the special benefit of persons that are brought socially in contact with soldiers, as such persons are in a particularly favorable position to witness the early stages of mental disease, and by their prompt and co-operative action may render valuable assistance in preventing nervous breakdowns. Reports from abroad indicate that a large number of the soldiers who break down nervously (shell shock) had, for several days before their final collapse, given evidence that they were fast approaching the limit of their nervous endurance. It is believed that had something been done for them during those critical days they would have readjusted themselves quickly and gone back to their duty instead of remaining nervous invalids, with little prospect of recovery before the end of the war. Nervous breakdowns often begin by sleeplessness, persistent homesickness, nervousness, depression, self-reproach, unreasonable fear, suspicion of others, feeling of resentment against others, and general complaints of ill health. These signs often show in the man's social conduct, so that he is remarked by his companions as being restless, jerky, inclined to stay by himself, bad tempered, etc.; in other words, his companions remark that some change has come over him. The man himself may realize that he is out of sorts, but often he does not realize that he is ill, and so does not report at sick call; on the contrary, he often resents the idea that he needs the care and supervision of a physician. Yet a little rest, care, and medicine, such as would be provided if his case were brought to the attention of a medical officer, would in all probability suffice at this time to put the man on his feet again."

"In Line of Duty"

A case to be discharged "in line of duty" and therefore with certain claims upon the government, is defined in the following order issued by the Adjutant-General (G. O. 47):

"Hereafter any soldier who shall have been accepted on his first physical examination after arrival at a military station as fit for service shall be considered to have contracted any subsequently determined physical disability in the line of duty, unless such disability can be shown to be the result of his own carelessness, misconduct, or vicious habits, or unless the history of the case shows unmistakably that the disability existed prior to entrance into the service. The same rulings shall apply in the cases of officers who have been passed as fit for service on physical examination upon entrance into the service."

Feebleminded and the War

A well-known American psychiatrist now on duty in France writes as follows: "And just one recommendation. Keep the feebleminded home. I know there is a difference of opinion as to whether or not there is any place for them in the Army. Maybe there is, but not *here*. They drop their Mills' bombs and run, they get cold feet and endanger the military reputation of the finest body of fighting men in the world, who are 'carrying on' before the most critical eyes. They get into disciplinary troubles and are dealt with, in nine cases out of ten, without reference to their feeble minds. If they are *not* children, all we have been saying about childish minds in adult bodies is sentimental rot. If they *are* children, the hell of the trenches is no place for a child. If anyone thinks that the officers of labor battalions have time or inclination to make special allowances for the feebleminded members of such organizations, he has not seen those organizations at work in France. If providing cannon fodder for the Boche's guns will help win the war, send them over. It won't; what will win the war is an Army of keen, alert, steel-nerved, clear-eyed American soldier boys who will outfight the Hun every time they meet him hand to hand."

The Trouble Buster, published at Fort McHenry, U. S. Army General Hospital No. 2, by the class in printing, gives an account in its issue of June 22, of the opening of the psychiatric ward at the hospital, when a joint meeting of the medical staff of the hospital and the Baltimore County Medical Society took place at this post.

". . . . At five the company assembled to inspect the new ward, which they found most attractive. The ward is for the treatment of mental cases in their early stages. Usually this treatment consists chiefly of mental hygiene, that is, of keeping the patient in an atmosphere of rest and quiet, though not one of indolence. He is given light work and recreation in due measure, so that his mind may be occupied with thoughts other than that of its own disorder. Some few patients will do their work in the court behind the ward; those who are not seriously ill will so far as possible work with the other patients in school and shop. Already Major Herring has succeeded in obtaining a fine spirit of co-operation from the patients in the ward, and all do their best to help along the others. This spirit of helpfulness bodes well for the increasing success of the work."

A Section of Anthropology in the Division of Medical Records in the Office of the Surgeon General has been created. Major Charles B. Davenport, Sanitary Corps, N. A., formerly Director of the Eugenics Record Office, Cold Spring Harbor, New York, is designated as the Officer in Charge. The functions of this section are to be: To secure the highest quality of the measurement of recruits and of identification records as done by the Surgeon General's Office for the Purposes of the War Department; to assist, as called upon, in the analysis and synthesis of the statistics compiled from medical records; to care for and help analyze physical examination records; to care for and classify identification records; and to assist the War Department in all questions about racial dimensions and differences.

TREATMENT OF WAR NEUROSES AT THE SEALE-HAYNE MILITARY HOSPITAL

The following account of the methods employed in the treatment of war neuroses at the Seale-Hayne Military Hospital, Newton Abbot, Devon, England, was recently received in a letter from Major A. F. Hurst, R. A. M. C., Officer in Charge of this hospital. Major Hurst was formerly in charge of the Neurological Section of the Royal Victoria

Hospital at Netley. This section has recently been given up, and the Seale-Hayne Military Hospital, with 225 acres of land, has been opened as a special institute for 300 or more men suffering from war neuroses.

The war neuroses can be classified into three main groups, which require different initial treatment, the treatment in the later stages being identical.

First Stage of Treatment

(1) *Hysterical symptoms.* Paraplegia, monoplegia, mutism, aphonia, stammering, tremor, contractures and disorders of hearing and vision are the most common hysterical manifestations. In the vast majority of cases they can be cured in a single sitting by pure persuasion and re-education. This can often be accomplished in a few minutes, but sometimes three or four hours of continuous treatment are required. Electricity is only used occasionally, when it is necessary to demonstrate to a patient that an hysterically paralyzed muscle is really capable of contracting. Hypnotism is now never used for these cases. The initial treatment must often be followed by systematic re-education by an instructor for a few days, especially in cases of long standing. With this exception the patients are put at once on the second stage of treatment which is described later.

(2) *Neurasthenia.* Only in severe cases of pure neurasthenia is any preliminary treatment required. This consists of rest in bed with complete muscular relaxation for a few days. The majority of cases are ready the day after admission for the second stage of treatment.

(3) *Psychasthenia, including nightmares, phobias and obsessions, and amnesia.* These conditions require "therapeutical conversation," in which the medical officer attempts to gain the patient's confidence and discusses intimately all his worries. In some cases hypnotism is required, but this is rarely practiced on more than three or four consecutive evenings and often only once. These patients are treated in isolation rooms by themselves, and are at first kept in bed. Frequently they are fit in a few days to do isolated work on allotments before entering upon the second stage of treatment.

Second Stage of Treatment

This is the same for hysterical patients, who have recovered from their symptoms, but require to be kept under observation for at least six weeks to prevent the possibility of recurrence, for neurasthenics, who require about the same length of treatment in order to recover completely, and for psychasthenics, who often require three months or more, and often then are only fit to be discharged from the service although this is never done until they are physically and mentally fit to earn a good living in civil life, requiring a pension of not more than 20 or 30 per cent. The patient is asked what was his occupation in civil life and in the case of skilled dairymen, horsemen, poultry-keepers, gardeners, engineers, plumbers, fitters, carpenters, etc., an attempt is made to let him follow his old occupation. Otherwise he is given ordinary farm work. The work is at first light and only lasts for a few hours in the morning and afternoon, but its severity and duration are steadily increased as improvement occurs. All non-specialist farmers have two days a week on hospital fatigues, the hospital work being run as much as possible by the patients themselves. They act as clerks, mess and nursing orderlies and are helping the engineers with the alterations and additions required to get the hospital ready for 300 or more patients. All of these men do half an hour's physical drill every day under an expert instructor. There is no work after 5 p. m. or on Saturday afternoon. At these times the patients are encouraged to box and to play tennis, croquet, bowls, skittles, golf, cricket and other games. The patients themselves organize and give a concert every Thursday evening and they have a cinema show every Sunday evening. An attempt is made to get rid of the hospital atmosphere so that the men come to regard themselves as farmers rather than patients. Already the results are much better than they were at Netley, where the facilities for carrying out this treatment in detail were much smaller. I hope to be able to send at least 75 per cent of the men back to full duty without a preliminary stay at a command depot after a period varying between six weeks and two months. The number should be further increased when the new army order is issued, which guarantees that any man recommended for six months' home service should not under any circumstances be sent abroad within this period. The remaining patients will be discharged from the service after between three and six months, but, as was the case at Netley, no man will be discharged until he is fit to earn a living and until he has made definite arrangements about the employment he will follow. It is always recommended that a pension not larger than 30 per cent should be given.

THE NATURE OF NERVOUSNESS IN SOLDIERS

Major Foster Kennedy, of the Royal Army Medical Corps (Harvard Unit), Neurologist to the Bellevue and New York Hospitals, writing upon this subject in the *Journal of the American Medical Association* for July 6, 1918, says;

"A conscious assumption of symptoms by soldiers in my experience—and in this I am completely supported by all other medical officers—is exceedingly rare; it is not rare for a man to go sick for a few hours to obtain a temporary alleviation of his lot, but very seldom does one meet a man malingering with a view to discharge from the service.

"The conditions under which the present war is being fought are the rudest and largest experiment in biologic adaptation to which the human race has been exposed. Before 1914, it seemed to most of us that civilization with its drains, and its banks, its social amenities by which to prevent friction of the emotions, and its policemen and law courts to stop even the suggestion of physical clash, had stifled in us any possibility of living in an environment of danger and destruction, of dirt and foul odors. In the vast majority, the power of the human animal to exist in quite novel and abominable surroundings has been amply vindicated; but in a certain number the adaptation has been less complete, and be it noticed these people have been most often those who found even the normal life of peace time a hard and tempestuous affair. . . .

"The emotions of fear and pain constitute together our machinery of self preservation; in most of us swathed in the cotton bandages of our civilized lives but little call is made on them. Constant exposure to imminent destruction in war produces, however, a tautness of the nervous system, a strain due to powerful excitement and, I would submit, to the organic stress induced by the mobilization of biologic instincts heretofore dormant. These instincts of self-preservation do not always, and perhaps not often, become conscious realizations. I mean that men, though in great danger, quite honestly may not feel afraid; their nervous systems may be said to be frightened, but their awareness knows no fear.

"This submersion of such a powerful emotive force below the threshold of consciousness is due partly, perhaps, to the person's knowledge of the debilitating effects on his energies of the entrance of fear into his conscious life, but much more, one feels sure, to the inhibitory influence of his morale. Now what is this thing we call morale? Is it not the expression in each soldier of his herd instinct, of his willingness to sacrifice himself for the benefit of his kind, and for the ideas held in common by his countrymen and himself? It is a loyalty to his mates, to his officers, to his regiment, to his nation, and, in the last instance, to the ideals of life for which his nation stands, and it is measured by his conscious willingness to suffer, his capacity for sacrifice in the common good. It is a quality born of the tribe, a product of gregariousness and so held socially in good repute. It is constantly expressed in thought; it is a real component of the soldier's conscious intellectual life. The shrinking from loss and the fear of death on the other hand are but rarely scrutinized in their realities; they are anti-social in trend and so are cast down, by good citizens into the limbo of subconsciousness. . . .

"For some months past I have been trying to discover something of the dynamic influences in our men, and I feel that a clue to the genesis of the neuroses is to be found in the antagonism on the one hand of the conscious emotions of loyalty and morale with their concomitant urge to self-sacrifice, and, on the other hand, the more or less satisfactorily repressed instincts for the conservation of individual life.

"The British soldier is not given overmuch to self analysis and investigation of his emotional processes; but questionings carried out as tactfully as possible have elicited in innumerable instances the information that being wounded, subsequent to or during heavy shell fire, is followed by a period of mental rest. And it would be strange were it otherwise. Such a man experiences a sense of an honorable relaxation of effort; he is, for the moment, quit of his obligation to others, and freed from his fear of death. Further, his fate for the moment is decided, and despite his pain, he feels himself more fortunate than many of his fellows whom many times he has seen horribly destroyed. He waits for the stretcher bearers to take him, and in most men there is a conscious hope of a time of rest and home-coming.

"In such experiences, there are satisfied at once the man's biological instinct for self-preservation and his social instinct of loyalty to his comrades and to that ideal of conduct which has been his buttress in times of agony and stress.

"The converse situation in which a soldier suffers the stupefaction and profound bewilderment consequent on exposure to heavy shell bursts without being wounded, is one in which the obligation to persevere still remains with him, together with a prospect of indefinite repetitions of like abominations, culminating, as after a time becomes certain, in horrible mutilation or death. Under such circumstances, the conscious morale and idealism of the man—qualities, as has been suggested, of later growth than other instinctive processes—become drowned with the rising tide of his desire for life. The longing for safety, usually overborne by his conscious will, becomes overwhelmingly insistent, and is expressed by the entire organism being given over to the phenomena of fear. The individual becomes in mind and body, an automaton impelled by one instinct and one emotion; the mind, dazed and numbed, ceases to record impressions and is later found to be for that period amnesic. 'Dumb and palsied by fright' are only popular expressions of the loss of special senses and the generalized tremors which ensue. The defensive reflexes, the dodging movements of the head, the sheltering movements of the arms and the crouching movements of the body maintained for hours and days, and, under improper influences, for weeks after the lapse of the exciting physical cause, are an indication of the continued emotional tyranny under which he labors.

"In different individuals this conquering of the nobler altruistic part of the man by the lower and more selfish instincts takes place in different ways. It may and most often does occur as the result of profound fright, as has just been described; or, after a long period of mental conflict and strain, there may come a situation carrying with it complexes of such emotional strength as to render almost helpless the will power to endure. Such a case was that of an officer of my acquaintance who, having borne the racking experiences of the landing and trench fighting at Gallipoli, one day, jumping to what he took for solid ground, found himself—as he put it with a gesture of infinite disgust—squelching thigh-deep in decomposed Turkish dead. For weeks this experience recurred to his consciousness both by night in dreams and by day in dreaded interruptions to his normal train of thought, rendering him for that period incapable of duty, a prey to the paralyzing influences of both repulsion and fear."

Major Kennedy points out the effect of suggestion by physicians in determining symptoms, and records a case interesting in respect both to the production of the symptoms and its cure:

"A motor truck driver, an Australian of fine character and physique, in the autumn of 1917 was worn out by constant night work in the front areas during which time his feet were almost always numbed with cold. He contracted so-called trench fever and was sent to the base. When in bed, he found that he had developed an acute dorsiflexion of the right foot and toes; this condition persisted through sleep and constituted a deformity of quite alarming appearance. Consultations were held in the case, and various opinions as to the character of the condition were expressed in the man's hearing. No conclusion was reached, and for some months electricity and massage were empirically given without modifying the position of the foot.

"An attitude of complete confidence on the part of the medical officer in his diagnosis and in his ability to cure the condition, followed by strong faradism to the calf muscles and to the sole of the foot, and then by rapid re-education in walking later abolished the spasm in two sittings. The purely mental nature of the ailment was explained to the patient; he was told how, when one wished to move, for instance, one's arm, it was necessary, first of all, to will to move the arm, how that act of will caused energy to come from certain brain cells, which energy went down through certain nerves to the arm, which then was put in motion. He saw quickly enough how an injury in either the battery, i. e., the brain, or the wire, i. e., the nerve tracts, could prevent movement taking place; whence, he came himself to the conclusion that in order to initiate the progress, it was also necessary to throw in the switch, i. e., the will to move.

"He was shown that by his defect of will power he had become for a time no longer master in his own house. It was made very clear to him, without, of course, crude words, that the medical officer knew he was not malingering, but appreciated and sympathized with his condition of fatigue which antedated the outset of the spasm. On the other hand, reference was made to the prolonged period of rest which had been his; our need of fit and capable men like himself was touched on, and there was brought to his mind the price daily being paid by our comrades for our security. In this way, his morale was stimulated and, with gratitude for his recovery, he applied for an immediate return to the line."

The term "shell shock," Major Kennedy holds to be inapt, and suggests the use of the term "nervousness":

"The essential feature of these ailments having been grasped, they must be classified and christened. In the beginning of this paper it was pointed out how the term 'shell shock,' founded on false premises, not only served to suggest an incorrect etiology, but also, by its pitiful and romantic sound, tended to perpetuate symptoms and to excite no determination in the mind of the sufferer to recover his control, or, in the fighting man, still to endure. So far is it from making an appeal to conscience or to discipline that it stifles both, and stultifies effort toward cure.

"The name is a mistake; we must be rid of it. Let us have instead a true term which will be neither a compromise nor a technicality, unintelligible to the mind of the soldier.

"Hysteria is unsuitable in that its significance to laymen and physicians is not identical; nor does it embrace, for instance, such conditions as the anxiety neuroses. The simple word 'nervousness' comprises all the neurotic manifestations seen in war. It furnishes an appeal to the sense of discipline in the armies, and further promotes the growth of public opinion, both military and civil, which would be of the greatest prophylactic and therapeutic power.

"This diagnosis would continue to be divided into nervousness (sick) and nervousness (wounded), as now obtains, according to the external conditions to which the man was exposed at the time of breakdown. This change in military nomenclature would make clear to both soldiers and civilians that such diagnoses need not necessarily be followed by a return to home or to the base, and would clearly indicate the propriety of dealing with such cases diagnostically and therapeutically in rest camps, and especially work camps, in front areas and on the lines of communication."

CAPTAIN SMITH—77

". . . . The inefficiency which springs from undue political influence has received from him [Secretary Baker] the greatest check in our military history; and this point in his policy is again illustrated, and illustrated magnificently, by General March's recent order requiring every American officer up to the grade of brigadier-general, to carry a terrible scientific card on which, from the hands of his purely military superiors, he receives a purely military and non-political technical 'rating.'

"This 'rating' system is one of the novelties and curiosities of the war. We have never before had anything like it, in method. It was devised by Walter Dill Scott, formerly a professor in psychology at Northwestern University and now Director of the War Department's Committee on the Classification of Personnel. Dr. Scott's proficiency in psychology might lead one to fear that he would 'rate' our officers by means of ergographs and electric currents and nerve-reactions and lists of memorized numerals and other psychological laboratory-tests. But he is guiltless. His 'rating' system now being applied to all our officers throughout all our camps, is based absolutely on 'practical' comparisons between man and man and not all on 'theoretical' deductions from laboratory-tests or, for that matter, from examination-papers. Laboratory-tests and examination-papers will weed out the feebleminded and will perform various other services. But our 'rating' system for the promotion of our sound-minded and sound-bodied officers to higher grades is a genuinely man-among-men system.

"Besides which, it is a fascinating game. Imagine yourself a Major. It is your duty to 'rate' all the Captains who are your subordinates. You proceed as follows:

"First, you make a 'rating-scale.' You make a 'rating-scale' for each of the five considerations on which you are going to 'rate' your subordinates. These considerations are: Physical Qualities, Intelligence, Leadership, Personal Qualities, and General Value to the Service. The greatest number of 'points' which you can give to any subordinate for General Value to the Service is 40. The greatest number you can give him for any one of the other four considerations is 15. The greatest possible total of 'points,' therefore, for the perfect officer is 100.

"You begin, we will say, with Leadership. You are about to make a 'rating-scale' for Leadership. You think of the officers you know of your own rank. You think of Majors. These Captains will be, or will not be, promoted to Majors. Among the Majors in your acquaintance, which one would you pick out as ranking highest, in your estimation, for Leadership, for 'ability to command the obedience and the co-operation of other men'? You mark him down at the top of your Leadership 'scale.' He is the maximum. He is 15.

"Now among all the Majors you know, which one is worst for Leadership? And which one is 'just about average'? You mark down the average Major, in the middle of your scale, at 9. You mark down the worst Major at the bottom, at 3. You now have a scale for Leadership, and it is made not of theories but of Majors. It is made of flesh and blood.

"Whereupon, equipped with this scale, you proceed to rate Captain Smith. You find that for Leadership, in your estimation, he is far above Major Black, at the bottom, and quite a bit above Major Gray in the middle, but clearly not altogether the man that Major White is at the top. Yet he approaches Major White, who is 15. You give him we will say, 14.

"For intelligence, having made an Intelligence scale, consisting again of Majors, you give Captain Smith perhaps only 8. Captain Smith is not brilliant. He has no conspicuous 'ease in learning.' And on Physical Qualities you can give him only 8. But on Personal Qualities, such as 'industry' and 'loyalty' and 'readiness to shoulder responsibility for his own acts,' he compares favorably with any Major you have ever met.

You would like to give him 16. But there is no 16. You give him 15. And on General Value to the Service, taking him all in all, especially on the question 'whether or not he can arrive quickly at a *sensible* decision in a crisis,' you decide, after comparing him with the Majors in your General Value scale, to give him 32, which is only eight short of the best.

"Captain Smith's total then is 77. It is a high total. The normal total is 60. That is, if a man gets the average rating, the middle rating, in each of the five rated considerations, his final totaled rating will be four 9's plus a 24—which is 60. Your average officer is 60. Captain Smith, with all his defects in verbal memory, and in chest-measurement, is well above the average. He might not shine at examinations. He might not shine at laboratory-tests. And he might make a less than an average impression, at first sight, on a new commander in a new camp. But here you have a rating-system which is not academic and which is not, nevertheless, merely impressionistic. It is a really human record, put into a scientific statement.

"Captain Smith carries his card with him to his next camp. And he carries it with him to France. General Pershing has particularly requested that every officer sent over shall bring his card with him. It goes in an envelope, sealed; and the officer delivers it, immediately on arrival, to his next superior. It does not determine his promotion. That is, it does not foreordain it. This system is not in any way a Chinese system. Captain Smith's rating, made by his Major and then revised by his Colonel, is not in itself conclusive to his superiors, but it is an element and it will be an increasing element, in their dealings with him.

"And it is beautifully conclusive to Senators and especially to Democratic Senators and to other most distinguished persons conscious of their political importance.

"Captain Smith's card, in duplicate, goes to Washington. It lies there in the War Department. So does Captain Jones's. Captain Jones is only 25 in his rating. The Adjutant General's office knows that he is only 25. And when a Senator or Congressman comes to intervene on Captain Jones's behalf and begins to describe him as the darling of his regiment and the hero of his regimental mess, the answer is ready and irresistible. Without this card, the War Department could only say that it preferred its own personal preference to the Senator's personal preference. With it, the War Department stands on figures. And yet, the figures, most happily, are personal preference, too—the personal preference of military persons, reached by a systematized comparison of military personalities in the field."—William Hard, in *The New Republic*, July 6, 1918.

THE MENTALLY DEFICIENT RECRUIT

Canada's experience with the mentally deficient recruit is thus described by Capt. O. C. J. Withrow, C. A. M. C., in the March number of the *Public Health Journal*, Toronto: "For there is no shadow of a doubt that mental defectives give great concern to a Medical Officer of a unit as soon as they have donned their uniforms. Every fellow may look alike in khaki, but every man doesn't act like his comrade any more than do the units in civilian life. Deficient mentality shows itself early or late. The greater the deficiency, the sooner the discovery. The sergeant reports that Pte. Bill Smith is too stupid to learn any drill. The cook house sends word that Pte. Tom Jones is no good around the pots and pans. The Sanitary Squad won't have the last man detailed to them; all he does is to stare at the landscape. The Medical Officer greets these recruits at his morning sick parade, and has very little difficulty in pronouncing a diagnosis—likewise a prognosis. The difficulty arises when an attempt is made to have such discharged from the army. This takes trouble and it costs money. These are the simple cases—what complexities are involved with the others!

". . . . Many loyal and devoted persons have expressed their convictions that it seems a great pity to send all the physically fit to fight our battles with the prospect of death or disfigurement, while those of lesser physical attainments are left at home. It seems a greater hardship that we leave behind the mentally defective while those of brighter intellect march off to do exploits. But what will you? War is war, and it takes the keenest and the bravest to stand the rigors of a campaign. And one deficient intelligence may cause a cataclysm of disaster in many an hour of expected triumph."

The first number of the *Revue Interalliée pour l'Etude des Questions Interessant les Mutilés de la Guerre* appeared in April. The subjects to be treated in this review are stated as the following: physiotherapy, prothesis, functional and professional re-education, and questions of economic and ethical import to disabled returned soldiers. The review is published bi-monthly, is edited by Dr. Jean Camus of Paris, and is the official organ of the *Comité Permanent Interallié pour l'Etude des Questions Interessant les Invalides de la Guerre,* of which Dr. Bourillon of France is President, and Charles Krug, also of France, General Secrétary. The membership of this committee includes prominent citizens of Belgium, Great Britain and her possessions, the United States, France, Italy, Montenegro, Portugal, Roumania, Russia and Serbia. The members from the United States are J. Caffery, L. A. Cresset, H. Folks, Grace S. Harper, Dr. A. Lambert, Dr. H. W. Miller, A. F. Sanborn, Dr. Veditz and Major S. H. Wadhams.

The first part of the review contains original articles by Professor Agathonovitch, Vice-President from Serbia: Brieux, member from

France; Professor Broca; Golonbeff and Dronsart, the former member from Russia; Professor Galeazzi and A. Lollini, the former member from Italy; Grace S. Harper, member from the United States; Madame Simone Laborde; General Melis, Belgian Vice-President; Joseph Neujean; Major Ripert; Constant Verdot, and Colonel Stanton, member from Great Britain.

The second part consists of reprinted proceedings of meetings of the Standing Interallied Committee and of the first Interallied Conference, of laws and proposed laws in Belgium, France and Italy, a list of reconstruction schools and agencies, and of books, articles, journals and miscellaneous works on the subject of reconstruction work with disabled soldiers.

BOOK REVIEWS

STANDARD METHOD OF TESTING JUVENILE MENTALITY BY THE BINET-SIMON SCALE WITH THE ORIGINAL QUESTIONS, PICTURES, AND DRAWINGS. By Norbert J. Melville. Philadelphia: J. B. Lippincott Company, 1917. 142 p.

This excellent little manual is intended for the training and use of advanced students of applied psychology who wish to co-operate in the work of grading and classifying children and others of juvenile mentality on the basis of their mental development.

Part I of this manual includes directions for using the standard record form which has been adopted by the public schools of Philadelphia. The grouping of the tests by years is identical with that of Binet and Simon, series of 1911.

The tests are divided into two series:—those shown to be most highly diagnostic in differentiating the mentally deficient from the normal; and those next in diagnostic value.

By using the Binet quotient (which the author explains), the Binet-Simon age-grade method becomes transformed automatically into a point-scale method, if one wants to use it that way. As such, the author claims for it superiority to any other point scale that has been proposed, because it includes a larger number of tests, and its points have definite meaning.

Principles for guidance in the administration of the tests and the evaluation of the data are included in Part I, together with a selected bibliography representing some of the numerous fields of activity where the Binet-Simon scale has proved valuable.

Part II comprises the "Uniform Method" of applying the Binet-Simon scale with notes suggesting supplementary trial variations. The "Uniform Method" is not another revision or adaptation of the Binet-Simon tests. The standardization is based upon the author's experience growing out of an application of the recommendations of the Buffalo Conference on Binet Testing, together with a comparative study of the methods used by other investigators.

Certain practical correlations appear to the author to be worthy of attention: that the qualifications in the matter of training and experience for Consulting Psychologists and Field Examiners be more accurately defined; that the Binet age score be not accepted on its face value, recommending instead its interpretation in terms of mental growth periods in the light of group norms and of supplementary data; and that, finally, instead of attempting to make adaptations of the Binet scale, investigators should strike out along new lines in the development of supplementary scales.

Orthogenic and psycho-educational tables are given in the Appendix, to serve as guides in the work of provisional classification.

A table of anatomical limits is given, and a method of collecting supplementary data is offered.

One can agree with the author that the method lends itself well to a study of deterioration groups, dements, etc., and furnishes valuable data for differential diagnosis in this connection.

The Uniform Procedure developed by the author is based upon more attention to detail than any other manual of directions we have seen.

Every word of the "Summary of General Procedure," on page 41, is well worth most careful perusal.

The limitation of this tool in mental diagnosis is well recognized by the author. Any measuring scale is in part only a convention adopted for practical purposes, and should only be used in connection with a complete study of the case, including all obtainable data—medical, psychiatric, social and such. These points the author clearly sees.

The reviewer takes pleasure in recommending this most carefully evolved manual. It can be read profitably by all students of mental diagnosis.

V. V. ANDERSON.

SYPHILIS AND THE ARMY. By G. Thibierge, M.D. London: University of London Press, 1918. 201 p.

This volume is one of a series of Military Medical Manuals translated from the French and published under the general editorship of the Director General of England, Sir Arthur Keogh, and edited by C. F. Marshall.

The aim of the book, which is written for medical officers in the army, is to provide them with adequate information about the nature, treatment and social effects of syphilis so that they in turn may influence public authorities, civil and military, to put in force all possible measures for its cure and the prevention of the further spread of the disease.

The volume may be divided into three main parts, the first dealing with the general problem of syphilis in France today, its incidence, mode of transmission and social effects; the second division considers the signs, symptoms and treatment, while the third discusses prophylaxis. It is the first part of the volume, in which the general social problem of syphilis is discussed, that is of most interest. Unfortunately this is quite brief, comprising but thirty-three pages of text. The author maintains that there has been a great increase of syphilis in France, since the beginning of the war in the army, munition works and among the civil population. Statistics are inadequate to express just what this increase is. It is estimated that there are from 4,000 to 5,000 contagions per month amongst the French troops, which in three years of war would make 150,000 to 180,000 infections.

It is found that soldiers at the front most often contract syphilis in the interior when on leave or in the depots before returning to the front. This accounts for about 70 per cent of the infections. In the army zone the chief danger is from women who are not professional prostitutes, i.e., restaurant keepers, barmaids, laundresses, seamstresses, farm maids; while in the base zone and among men mobilized in munition works, venereal diseases are most often transmitted by the professionals. Among munition workers the incidence of syphilis is very high. Since men and women are thrown close together, immorality has been common; many prostitutes, finding their incomes diminished because of the absence of their clientele at war, have taken work in munition factories, plying their trade at the same time.

Syphilis has increased among the civil population as well as among the soldiers. Here it is the married women and young men who are the victims. The increase among married women is ascribed to the long absence of their husbands, diminished incomes and infection by their husbands who have acquired syphilis while in service. The young men are solicited by the prostitutes who, finding their usual customers absent, entice the boys not old enough to enter service.

The author summarizes the evil consequences of syphilis among soldiers as follows: "(1) It compels patients to submit to treatment which during the contagious periods cannot be carried out at the front, or while men are still engaged in munition works, because in a word it diminishes the effectives; (2) it diminishes a man's value; (3) being transmissible to a patient's descendants, it compromises the race at an epoch when, more than ever before, it is imperative that the race should be numerous and robust."

The bulk of the volume is now given over to a discussion of the symptoms, diagnosis and treatment of syphilis as observed in the army. The facts given do not differ in essentials from the known facts of symptoms, diagnosis and treatment in civil life, except that certain methods of treatment are preferred owing to the exigencies of military routine, such as the difficulty of procuring supplies and frequent reporting to physicians. The ideal of treatment that it "should be instituted in such a way that it will reduce to a minimum the ineffectiveness of the soldiers" is certainly one which should be current in the civil hospitals.

In the last portion of the book, the author deals with the prophylaxis of syphilis, once more emphasizing syphilis as a social danger. He takes up precautions for preventing the transmission of syphilis by infected men, such as isolation of carriers, adequate medical inspection and hospital treatment not only for soldiers at the front but for the munition workers, the creation of venereal centers in the army zone as well as in the interior, and post-hospital supervision; for noninfected men he advises personal talks with army physicians as well as lectures and distribution of pamphlets; for the civil population he favors the increase in the creation of centres for the treatment of syphilis, which has met with success in France, and supervision not only of known but of suspected prostitutes, a measure which has not been carried to the end in France.

The first thirty-three pages of the book give the information of chief value and interest. One wishes that more space had been allotted to this section rather than to the remainder of the book, which is in reality a manual of syphilis. As such it has a certain value, being brief, discussing the symptoms most likely to be found in soldiers and presenting the question of treatment from the standpoint of the exigencies of military service. However, one feels that it is elementary and incomplete. While of undoubted value to the busy military surgeon, it can hardly be considered as an addition to syphilology as a science.

The last division, dealing with the prophylaxis of syphilis, is sane and views the problem from a practical but wide angle. The suggestions merit study and consideration.

The book is written in a very clear and simple style. Directions for handling individual patients and army clinics are explicit and complete. To the military surgeon who is suddenly confronted with the necessity of treating syphilitics, it will be a most useful guide.

While calling attention in a forceful manner to the great dangers of syphilis, it is in no way sensational, and the facts and figures so carefully collected and compiled in the first section of the book are worthy of reprinting for purposes of propaganda.

HARRY C. SOLOMON.

NEUROSYPHILIS: MODERN SYSTEMATIC DIAGNOSIS AND TREATMENT. By E. E. Southard, M.D., Sc.D., and H. C. Solomon, M.D. Boston: W. M. Leonard, 1917. 496 p., illus.

In recent years the abundant literature relating to syphilis of the nervous system has shown a vast amount of study devoted to the subject. In presenting "Neurosyphilis," Southard and Solomon give a concrete analysis of their experience and study, and frankly point out the lessons to be derived therefrom. The first lesson is the unity-in-variety of the phenomena, by which is meant the spirotrichosis and its corollary the Wassermann reaction as the one constant in an almost endless variety of other phenomena. The second lesson is the value of a hopeful attitude toward therapy in all cases, even those of general paresis. The third lesson is the necessity of a complete serological study of every case of neurosis or psychosis. The book is stated to be written primarily for the practitioner and secondarily for those whose special work deals more constantly with syphilis in some form, for example, the psychiatrist and the neurologist. One feels that the majority of neurologists and psychiatrists will charge the writers with polite modesty, for except to workers in a few large clinics no opportunity is given for such clinical, serological and pathological experience as forms the basis of this study. The material was furnished by over two thousand cases of syphilis of the nervous system in various stages and manifestations, supplemented by the study of over a hundred autopsies. Most of the patients came through the medium of the Boston Psychopathic Hospital, but those who are familiar with the close relationship which exists in fact, and not theory, with the Massachusetts public, due to the untiring personal efforts of Dr. Southard and the Massachusetts Commission on Mental Diseases, know that the problems presented by the patients studied differ in negligible degree from those seen in actual civil practice. The 137 cases which they cite confirm this. There is however a preponderance of the psychotic manifestations of neuro-syphilis, which is hardly a fault. Enough cases of syphilis of the spinal cord, root and peripheral nerve are presented to emphasize the lessons mentioned above, but not enough perhaps to cover the clinical display seen by the neurologist as distinguished from the psychiatrist. It is not the purpose of the book to include all those nosological entities. The work, therefore, can claim attention through the wealth of clinical and pathological material. But still further and more important claims rest on Southard's well-known interest and productive work in neuropathology and neuropsychiatry, and Solomon's recent intensive studies in the serology and treatment of neurosyphilis. Added to this is the close and efficient relationship of a splendid social service in the study of the entire subject. All of these things are well known of course to the friends of these Boston workers.

In the first chapter, entitled *The Nature and Forms of Syphilis of the Nervous System*, the writers quietly attack the problem of classification, and without urging its acceptance present one of their own to which they adhere pretty closely throughout the book. For the entire subject the term neurosyphilis is used, of which the main forms are: diffuse, vascular, paretic, tabetic, cummatous and juvenile. Any of these forms may be further qualified by indicating in appropriate terms the combinations of meningeal, vascular and parenchymatous involvement. Whether one is disposed to criticise this classification or not, there is a certain testimony of approval seen in the frequent use in the recent literature of the terms neurosyphilis, neurosyphilis tabetic type, etc. If there is any chance for further subdivision, it is in the group diffuse neurosyphilis, but thus far no one has succeeded.

As stated above, the book is made up of 137 case histories, each chosen to illustrate a given principle and presented with just enough detail to make it clear. Aside from the variations in the different cases the authors with true literary instinct hold one's attention by individualizing each person, so that he appears before one as a patient with a name (fictitious of course) and is so remembered. The first case, of Mrs. Alice Morton, is presented as a paradigm to show the possible abundance and variety of symptoms and lesions in diffuse neurosyphilis. The clinical and histo-pathological findings are unusually rich and afford the authors a good opportunity not only to indicate the diffuseness of the syphilitic lesions but to correlate the clinical with the anatomical data. Furthermore, stress is laid on the fact that many of the symptoms are irritative, or at least due to lesions which are entirely recoverable. The other cases in this chapter include similar clinical and pathological studies of typical cases of tabes, paresis, juvenile paresis, vascular neurosyphilis, gummatous neurosyphilis and basilar meningitis. The reader is given an anatomical and pathological foundation, which is the only true way to approach the diagnosis and therapy of this protean disease.

The chapter on *Systematic Diagnosis* covers a wide range of cases both mental and neurological, with several striking examples of congenital syphilis. Some of the not unusual forms are omitted, such as the myelitides, 'cases of root pain, tri-geminal involvement, labyrinthine disturbance, etc. Especial attention is given to the diagnosis of paresis. Very striking is the statement that diffuse neurosyphilis may look precisely like paretic neurosyphilis at certain periods of clinical and laboratory examination. A similar statement appears in the preface: "We are confident that no one can now successfully make a differential diagnosis between the paretic and diffuse nonparetic forms of neurosyphilis in many phases of either disease." Attention also is drawn to the fact that remissions of identical appearance occur in paretic and in diffuse neuro-syphilis. The particular emphasis of this chapter is, however, put upon the serological tests, and a careful analysis is made of the variations found not only in the particular types but in the individual cases. The colloidal gold test has been given a prominent if not absolutely dependable place in diagnosis. In the authors' experience fluids from cases of general paresis in the vast majority of instances give a strong and fairly characteristic reaction, although very rarely the reaction will be weaker. While nonparetic cases in a fairly high percentage give the same reaction as paretics, still when the fluid does not give a strong paretic reaction it is presumptive evidence that the case is not general paresis. With this interpretation of the gold sol reaction, serological study has directed attention to an important group of cases, the so-called "paresis sine paresi" group, which calls for final interpretation in the light of further clinical study and subsequent history.

The chapter on *Puzzles and Errors* deals with a wealth of material illustrating many atypical forms of neurosyphilis, or what Collins sometime ago well described as "Unsuspected Syphilis in Neurology." Almost the whole gamut of psychotic disturbances is covered and many neurological syndromes, in all of which certain physical and serological signs compel the diagnosis of neurosyphilis. The difficulty of properly interpreting neurasthenia, hysteria, dissociated states sometimes seen in undoubted syphilitics, is touched upon. The confusion which alcoholism, senility, brain tumor and pernicious anemia can cause is indicated. The whole chapter presents excellent points for differential diagnosis, in which the authors display a nice consideration of symptomatology, a ready reference to the literature and an easy familiarity with the serology and pathology of neurosyphilis.

Two short but timely chapters appear on neurosyphilis in its social, medicolegal aspects and on neurosyphilis in the war. No thoughtful person can fail to appreciate the bearing this disease has on the family, public, social and economic life of the individual. Our Government has already met its responsibility by discharging from the army every recruit showing signs of neurosyphilis. The case histories are interesting and suggestive, and the rules for the interpretation of the various problems involved quite clear. For the timid among us who fear causing unhappiness and breaking up of families by attempting to examine wives and children of syphilitics, there is much food for thought in the statement that "in doing this as routine for nearly three years and examining several hundred families there has been no instance to our knowledge in which the family has been broken or grave difficulties encountered."

The chapter on treatment is the best in the book. No better example of the author's general method of presentation of problem, attack and solution can be found. The whole subject of treatment is prefaced by the clinical history and autopsy records of five cases of neurosyphilis. Detailed analysis of the pathological conditions makes apparent what difficulties therapy must face, and proof is given that clinical study alone cannot anticipate the histological picture. The difference between inflammatory and degenerative lesions must be acknowledged. Meningitic processes can possibly be removed by treatment, but the degree of ultimate recovery depends upon the condition of the brain substance. Some cases show changes in infragranular layers and are unfavorable; some are associated with marked brain atrophy and are obviously hopeless for improvement. The degree of atrophy found at autopsy cannot at all be postulated by consideration of the duration or severity of the disease clinically. Further there are variations in the topographical distribution of lesions, and a case that may seem mild clinically may reveal at autopsy extensive involvement. On the other hand, the perivascular infiltration of lymphocytes and plasma cells does not warrant pessimism, for a somewhat similar condition, but without plasma cells, occurs in acute poliomyelitis. And still more encouraging is the fact that many of the symptoms are not due to parenchymatous degeneration but to various microphysical conditions of pressure and intoxication. One question awaiting solution is data regarding the precise habitat and toxic activity of the spirochæte. The prognosis therefore is not bad, even in paresis, for one may not by any means be sure it is paresis. In all fairness the prognosis should be made only after treatment has been tried.

The kind of treatment advised is intensive treatment with the salvarsan products as the main weapon. All methods are used, the precise one or combination depending on the individual case. It is admitted that the last word as to the best method has not been said, and no attempt is made to advocate any one. Many case records are cited, most of them considered paresis clinically, some of them diffuse neurosyphilis and tabetic neurosyphilis. Results were strikingly good, partial, or admitted failures. No charts are given showing percentages. While opposing therapeutic nihilism or optimism, a plea is made for hopefulness in approach toward each case, not only in view of actual results already obtained in some cases but because of the admitted chance of error.

In general, the chapter on therapy is the most temperate we have seen. It will be a comfort to many workers in this field who have been at least puzzled by various published reports showing percentage results of cure or improvement that seemed beyond them. By showing that the problem is individual in each case because of the variations in the pathology and the amenability to treatment, a considerable advance has been made in the therapy of neurosyphilis.

In reading the book there are several things that attract attention. The authors understand thoroughly the value of order, emphasis, repetition and summary. The blocking of essential statements in heavy type as a heading to each case history is very effective. The discussion of the unusual symptoms by questions and answers lends clearness and is seldom tiresome. The authors' style is charmingly direct and animated, and the book has a subtle entertaining power seldom seen in a purely medical treatise. Everywhere there is evidence of thoughtful consideration, from the appropriate frontispiece to the unique summary and key, not forgetting the quotations from Dante, which perhaps had best been reserved for a smaller audience of understanding friends. Finally, praise must be extended to the publisher for the clearness of the pathological sections, the best we have seen in any American book, and for the physical excellence of the book itself. Mention is made of these things because they are somewhat exceptional.

GEORGE J. WRIGHT.

NERVOUS CHILDREN; PREVENTION AND MANAGEMENT. By Beverley R. Tucker, M.D. Boston: Richard G. Badger, 1916. 147 p.

In this book the author does not profess to give a very systematic exposition of the nervous disorders of children; he discusses in a somewhat discursive way the problems which are associated with the nervous child. With regard to the familiar symptoms and disorders, the author gives us an enumeration and description rather than a discussion of the underlying causes and the special mechanisms involved. In the chapter on the cause and prevention of nervousness in children, mention is made of the ductless glands in somewhat disproportionate detail; the advice as to prevention of nervousness is common sense. Special chapters are devoted to defective children and to some organic and functional nervous diseases. The book is written in a pleasant style and can be read rapidly.

C. MACFIE CAMPBELL.

CHILD BEHAVIOR; A CRITICAL AND EXPERIMENTAL STUDY OF YOUNG CHILDREN BY THE METHOD OF CONDITIONED REFLEXES. By Florence Mateer, Ph.D. Boston: Richard G. Badger, 1918. 239 p.

The author devotes the first three chapters to an interesting historical review before passing to the special methods of the Russian school, especially to those of Krasnogorski. Krasnogorski studied the formation of certain associations in young children, or, in other words, certain conditioned reflexes. In the ordinary or unconditioned reflex act the individual reacts to the stimulus in an adaptive way which is part of the instinctive pattern of the individual constitution. Thus a dog begins to salivate when meat is shown to him. It is possible to develop in individuals similar reflex reactions which are not part of the instinctive pattern of the animal's nature, but which are derived from the simple instinctive reactions through the experience of the individual. Thus a dog accustomed to hear a certain musical note before seeing meat will soon develop the reflex act of salivation in relation to this musical note even though the meat is not shown. It is obvious that facts of this nature are fundamental for any study of the process of learning, which essentially consists in the development of associations.

Krasnogorski utilized this method to see how quickly in children certain associations could be learned and unlearned. On the basis of his data he concluded that the method was of use for clinical purposes. He found that in neurotic children associations might be easily developed, but were dissolved with very great difficulty. This is an important observation in relation to the functional neuroses where we find that a single episode may leave such a profound trace that the later reactions of the individual are seriously modified by it. Krasnogorski observed that young children reacted to the sight of food with swallowing movements, salivation and mouth movements. He tested various children with regard to the length of training necessary to associate these movements with artificial stimuli such as cutaneous or sound stimuli.

In the present work the author gives us a concrete example of the application of this method. She has applied it to seven low-grade defectives, to a normal child studied intensively, and to a more or less unselected group of fifty children. The detailed conclusions of the author cannot be summarized, and the book is more interesting from the point of view of method than from that of results. It is, however, a good example of a very promising new method of approaching the study of childhood in a sound and objective manner.

C. Macfie Campbell.

Educational Psychology. By Kate Gordon. New York: Henry Holt & Co., 1917. 294 p.

The influence of genetic and experimental psychology upon education is illustrated by this book. The concrete facts it contains are in striking contrast with the sorry platitudes that largely made up some of the older books on educational psychology. The author does not hesitate to begin with the growth and development of the human body, noting the conditions of physical growth, the distinction between chronological and physiological age, the importance to pedagogy of a knowledge of physiological and psychological development; and then she passes to the growth of behavior, instinct, the motor capacities of children, motor development, and the educational value of manual exercises, with hygienic and pedagogical suggestions.

Especially significant is the attention given to learning rather than teaching; the learning process as shown by observation, tests, and experiments; together with the economic methods of committing to memory, as suggested by the long series of experimental investigations from the pioneer work of Ebbinghaus to the studies of Meumann and Radosaljevitch, showing the advantages of the whole method for certain kinds of work, the importance of adapting one's method to one's individual type, the growth of memory with age, and the like. The author treats also of the mental processes of imagination, attention, feeling and will in relation to pedagogy, and briefly of the teaching of language, drawing and arithmetic.

A distinct merit of the book is the author's concrete statement of significant facts from the genetic point of view. This may be illustrated by the short chapter on the growth of reason which is in part as follows:

It is an easy matter to know a good memory, but it is often hard to recognize an act of reasoning. Reasoning is a new relating of terms. It depends on the ability to use symbols and concepts. It is sometimes identified with the classification and definition of experience. "It is an *ideal experiment;* it is synonymous with ingenuity in the *solution of problems.*" Children are concrete in their thinking. "Names mean to them the first tangible object with which they are associated. I know of a little Catholic child who thinks that the Holy Ghost is his left shoulder! In making the sign of the cross he, it seems, always touches his left shoulder at those words. When children learn to count they associate the number names with individual objects. Thus, if you count on the fingers for a child, calling the thumb 'one' and the little finger 'five,' he will object if you start back the other way and call the little finger 'one,' because you just said it was 'five.' He takes all nouns as proper names at first. The child makes two kinds of errors; he attaches general names to particular objects, and, on the other hand, names which properly attach to special objects, like 'father,' he extends to any similar object and calls every man 'father.' The child starts with an experience which is neither general nor particular, and it is his task to work out the difference between the two."*

Meaningful associations are logical relations. The opposites test is probably the easiest of the logical relations tests. The list of easy opposites used by Woodworth and Wells ought to be answered by eight-year-old children with a score of about 95 per cent. Definition has been used by Binet and others as a test of intelligence. Up to the age of four he finds that a child cannot define. Definition by use is characteristic of children between the ages of four or five and nine. After nine the majority of children can give definitions that are better than by use. The young child classifies but does not define.

Since the principles of mental economy are not very remote from the principles of mental hygiene the book has its contribution to the latter subject as well as to educational psychology and gives a convenient résumé of many of the results of the significant psychological studies of recent years.

William H. Burnham.

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WAR NEUROSIS AND MILITARY TRAINING*

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Discussions concerning the causation of the war neuroses usually deal with two main topics. Either they consider the predisposition to nervous disorder of those who have broken down under the shocks and strains of warfare, or they are concerned with the relative shares taken by physical and mental factors as the immediate antecedents of these failures. In connection with the first topic, various writers have discussed the part taken by congenital or acquired tendencies to nervous or mental instability as shown either by family history or by the occurrence of nervous troubles before joining the army. Under the second heading have been considered especially the part taken by exhaustion, concussion or emotional shock as the immediate precursors of a nervous or mental collapse, or by conditions of strain and anxiety which have lowered the resistance of the soldier to the shock or illness which was the immediate antecedent of his failure.

These two topics do not exhaust the causes of war neurosis. Between the time that a man joins the army and that at which he breaks down, he passes through a special experience, very different from that of any form of civilian life. He is first subjected to a special training, and when this training has reached a certain degree of perfection he meets another set of experiences, perhaps even more remote from those of civil life, in which he has to perform the military duties he has learned during his training.

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* A report to the Medical Research Committee, London. Publication approved by American and British Military Authorities.

Two separate problems must be distinguished: one, the relation of military training and the nature of military duties to the occurrence of neurosis; the other, the part taken by these factors in determining the special form which the neurosis takes. There is little question that one of the chief causes of the great prevalence of nervous disorders in the present war is that vast numbers of men have been called upon to endure hardships and dangers of unprecedented severity with a quite insufficient training. There is equally little doubt that the special nature of the duties involved in trench warfare has taken a large part in determining the great frequency of neurosis.

It is not, however, the purpose of this report to deal with the problem of the part taken by military training and military duties in the causation of neurosis in general. Its aim is to deal only with the second of the two problems stated above. For this purpose it is necessary to consider briefly the varieties of war neurosis, the main headings under which the almost infinite variety of its symptoms can be classified.

Excluding from the category of neurosis cases of simple exhaustion or concussion and disorders of circulation or digestion due to infection, and excluding also definite psychoses, cases of war neurosis fall into three main groups, though intermediate and mixed examples are of frequent occurrence.

The first group comprises cases in which the disorder finds expression in some definite physical form, such as paralysis, mutism, contracture, blindness, deafness, or other anaesthesia, or in some form of convulsive seizure. The characteristic common to all these symptoms is that they are such as can be readily produced in hypnotism or other state in which suggestion is especially potent. I propose later to consider how far the considerations to be brought forward in this report help us towards a satisfactory nomenclature. In the meantime I shall be content to speak of this group as hysteria, the term by which it was generally known before the war and one which, in spite of its unsatisfactory character, is still widely used.

The second group consists of cases in which the disorder shows itself especially in lack of physical and mental energy, in disorders of sleep and of the circulatory, digestive, and urogenital systems. On the mental side there is usually depression, restlessness, irritability and enfeeblement of memory, and on the physical side tremors, tics, or disorders of speech. This group is usually known as neurasthenia in this country, but in this case I shall anticipate the results of my later discussion and speak of it by the term anxiety neurosis.

The third group, with which I shall have little to do in this report, is characterized by the definitely psychical form of its manifestations. This group comprises a number of different varieties. In some cases the most obvious symptom is mental instability and restlessness with alternations of depression and excitement or exaltation, similar to those of manic-depressive insanity. In other cases there are morbid impulses of various kinds, including those towards suicide or homicide. In others the chief symptoms are obsessions or phobias, while others suffer from hallucinations or delusions. The special feature of all these cases is that the symptoms resemble in kind those of the definite psychoses, but have neither the severity nor the fixity which makes the seclusion of the patient or any legal restriction in the management of his affairs necessary.

There is no evidence that the psychoneuroses of the third group are especially liable to affect either officers or men, but the other two groups show a remarkable difference in this respect which I propose to take as my guide in the treatment of the subject. The group which I have provisionally labelled hysteria is especially apt to affect the private soldier. Pure cases of this kind are rare among officers who, as a rule, only suffer from this form of disorder as complications of states of anxiety, or when there is some definite, physical injury to act as a continuous source of suggestion. Anxiety neurosis is not similarly limited to officers, but affects them more frequently, and usually more profoundly, than the private soldier.

I propose to take this difference in the incidence of the two chief forms of neurosis as a clue to the better understanding of the nature of these states. I hope to show that this difference can be largely explained by differences in the character and effects of military training and military duties. For this purpose it will be necessary first to state the general theory of the neuroses of warfare upon which my treatment of the subject will be based. This theory is that the neuroses of war depend upon a conflict between the instinct of self-preservation and certain social standards of thought and conduct, according to which fear and its expression are regarded as reprehensible. From infancy the influence of parents and teachers is directed to bring about the repression of any manifestation of fear, and since the ordinary life of the modern civilized adult rarely presents any features which come into conflict with the instinct of self-preservation, this repression meets with little opposition and rarely produces any serious conflict. The child has many experiences which tend to call forth the emotion of fear in its cruder forms, but once adult age is reached, occasions which tend to produce fear rarely occur, and there is little in the ordinary life of the modern civilized man which tends to set up any conflict between the instinct of self-preservation and acquired social standards.

The business of the soldier, on the other hand, is one which necessarily brings its follower into the presence of danger, and as we shall see, one of the chief objects of military training is to fit the soldier to meet the special assaults upon the instinct of self-preservation to which his calling will expose him. In one of the two chief forms of war neurosis the conflict is solved by the occurrence of some disability—paralysis, contracture, mutism or anaesthesia—which, so long as it exists, incapacitates the patient from further participation in warfare and thus removes all immediate necessity for conflict between instinct and duty. Anxiety neurosis, on the other hand, is a state or process in which the conflict has not been solved but is unduly active, the controlling social factors having been weakened by exhaustion, illness, strain or shock, so that the motives arising out of the instinct of self-preservation have gained in power, while in many cases the social factors have produced new conflicts and causes of anxiety which may be as potent as the primary conflict with the instinct of self-preservation.

The object of this report is to consider the part taken in this conflict by the processes of military training and military duties, but before considering this, it will be well to inquire whether the life of officer and man before the war provides any reason why the two should be affected in different ways by the strains and shocks of warfare.

One possible cause may be found in difference of general education. On the whole the officer is more widely educated than the private soldier; his mental life is more complex and varied, and he is therefore less likely to be content with the crude solution of the conflict between instinct and duty which is provided by such disabilities as dumbness or the helplessness of a limb. The histories of officers suffering from anxiety neurosis often show the existence of temporary mutism, paralysis or other functional disability in the early stages of their illness, but these solutions of their conflict do not satisfy them and their disabilities speedily disappear, to be replaced sooner or later by symptoms directly dependent on anxiety.

Another possible cause is to be found in the quality of the education, and especially the school education of officer and man. Fear and its expression are especially abhorrent to the moral standards of the public schools at which the majority of officers have been educated. The games and contests which make up so large a part of the school curriculum are all directed to enable the boy to meet without manifestation of fear any occasion likely to call forth that emotion. The public school boy enters the army with a long course of training behind him which enables him successfully to repress, not only expressions of fear, but also the emotion itself. A similar schooling forms part of the education of the primary schools whence the majority of private soldiers have come, but it has been less extensive and less systematic than in the public boarding schools, though it is probable that the popularity of certain games has done much to lessen the difference in recent years.

If the behavior of the officer and private soldier after they have become the victims of neurosis is any guide to their standards before the war, the private soldier has far fewer scruples about giving expression to his fears, this expression being both more explicit and less subject to repression.

These differences must only be taken in the rough and as applicable on a large scale, but there is little doubt that the average private enters upon his military training with less aversion from the expression of fear than the average officer, and that his simpler mental training makes him more easily content than the officer with the crude solution of the conflict between instinctive and acquired motives which is provided by some bodily disability.

The liability of officers and men to different forms of war neurosis is thus partly capable of explanation by differences in the conditions to which they have been exposed before the war. It is the object of this report to show that these or any other conditions* existing before the soldier joins the army are greatly assisted by differences in the nature of the training of officers and men and of the duties which fall to their lot.

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* Among other possible conditions, those arising out of the influence of heredity should not be neglected.

I will begin by considering the general aims and character of military training. Its two chief aims are to fit each individual soldier to act in harmony with his fellows, and to enable him to withstand the stresses and trials of warfare. Military training is designed to enable the soldier to act calmly and methodically in situations which would naturally tend to upset the balance of his conduct and in the face of dangers which would arouse the instinct of self-preservation. Its aim is to free the soldier, not merely from the danger of succumbing to the collapse of terror or the blind flight of panic, but also from those minor disturbances of efficiency which are due to apprehensions or to doubts concerning the issue of a combat. The ideal military training should bring the soldier into such a state that even the utmost horrors and rigors of warfare are hardly noticed, so inured is he to their presence and so absorbed in the immediate task presented by his military duties.

In carrying out the two chief aims of military training certain definite agencies are called into play. In fulfilling the first aim of adapting the soldier to act as one of an aggregate in complete harmony with its other members, one agency is habituation. The elementary drill of a soldier consists of processes in which this agency plays a most important part. The soldier is thoroughly drilled in certain relatively simple evolutions until he has acquired the habit of immediate and unreflecting response to a command by means of which his reactions correspond with those of all the other members of the aggregate; all act together as if there were one mind in common to the whole. The individual soldier has to sink his individuality in order to act without hesitation or reflection as one of a section, platoon, company, battalion, or still larger group. The requirements of modern warfare are leading to some modification of this mechanical aspect of military training, but such modification only begins after the soldier has been subjected to a prolonged course of drill designed to adapt him to act as one of an aggregate.

An agency working with habituation, and one far more important from our present point of view is suggestion.* The process by which an individual comes to act promptly and harmoniously as one of an aggregate is simply one variety of the process by which individuals come to act as members of social aggregates in general. A person who is being drilled is taken from our highly individualistic community, in which spontaneity and independence are encouraged, and is subjected to a course of training calculated to produce a state allied to that of existing communistic peoples or of animals which are accustomed to act in herds. One result of such a training, if it be not indeed also its chief aim, is to enhance the responsiveness of each individual to the influence of his fellows, and the form which is taken by military training is especially designed to enhance his responsiveness to those who are immediately above him in the military hierarchy. From one point of view the most successful training is one which attains such perfection of this responsiveness that each individual soldier reacts at once, not merely to the expressed command of his superior, but is able to divine the nature of a command before it is given and acts as a member of the group immediately and correctly, even when the conditions of warfare might produce uncertainty if he relied entirely on the actual words or definite gestures of command. The process by which a capacity for such immediate response comes into being resembles very closely, if it be not actually identical with, the process we call suggestion. In the hypnotic state, in which the power and efficacy of suggestion reach their acme, the individual responds immediately and without question or hesitation, not merely to the command of his hypnotizer, but even to a desire or impulse of the hypnotizer's mind which is not expressed by speech or obvious gesture. The resemblance between the two states is so close that there is little doubt that one result of military training, and especially that of the more elementary forms of drill, is to enhance the suggestibility of those who are subjected to the process. It produces a modification of character which makes the soldier more immediately responsive to suggestion, whether this emanate from an individual officer or from the general body of the group, whether platoon, working party, company or other body which forms the aggregate of which he is a member at the moment.

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* Another process or agency which might be considered here is imitation, but this process is probably only important in military training in so far as it depends upon suggestion.

This enhanced responsiveness has been well exemplified in certain well-known incidents occurring in the army which has carried the more mechanical aspects of military training to an extreme length.* The success of the Captain of Koepenick could only be possible in an army whose members had through a special course of training reached such a pitch of responsiveness to the commands of one in uniform that they obeyed without question the ludicrous orders of a cobbler.

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* Ferenczi (see *Contributions to Psycho-Analysis*, Boston, Badger, 1916, p. 58) has incidentally alluded to the similarity between the command of an officer and the suggestion of a hypnotist. He records how during his military service he saw an infantryman instantaneously fall asleep at his lieutenant's command.

The other aim of military training which especially touches the liability to different forms of neurosis is to fit the soldier to withstand the trials and stresses of warfare. One of the chief instruments by which this aim is met is the one already considered, which makes the individual soldier act as a member of the aggregate to which he belongs in a closer sense than holds good in civil life. This does away with or diminishes greatly the tendency of any one individual in the group to react to fear or other emotional state in a way which would interfere with his military competence. In carrying out the aim of adapting the individual soldier to withstand the dangers of warfare, the first instrument is identical with that by which his actions come to be performed with the requisite immediacy and harmony. I have now to consider the processes by which the soldier collectively is assisted to withstand the stresses of warfare. These processes bring into action two chief agencies, repression and sublimation.

In considering the process of repression in its relation to military training, two varieties must be distinguished. In the first variety an attempt is made to thrust some part of the mental content, some feeling, thought, memory or sentiment, from consciousness. In the second variety the effort is directed rather to the repression of the outward expression of some mental state, especially of feeling or emotion. There is no hard and fast line between these two forms. One who endeavors to control the expression of an emotion will also try to banish from his mind thoughts or memories likely to call the emotion forth. Since, however, it is the expression of an emotion which is appreciated by others, the repression of the outward manifestation bulks more largely in the process in so far as it is a feature of military training. There are probably great individual differences in the way in which different persons treat the conscious elements of the mental content in their efforts to subdue their outward expression. As I have pointed out elsewhere,* repression forms a necessary part of all education and adaptation to social life. Perhaps the most important feature of the repression of military training is the relatively late period of life at which it takes place. The older a person is, the more difficult it becomes for him to give up habitual modes of thought and action. It is where repression is incomplete and is the source of persistent mental conflict that it becomes a factor in the production and maintenance of neurosis. If the repression which forms part of military training is complete, it probably helps greatly towards the success of the repression which will become necessary when the soldier enters upon active service, but if it is incomplete, so that the soldier enters upon active service accompanied by the active conflicts so aroused, his success in the necessary repression of warfare will be prejudiced.

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* *Lancet*, vol. 194, 1918, p. 173, or *Proceedings of the Royal Society of Medicine*, vol. 11, 1918, Section of Psychiatry, p. 1.

During military training much may be done, especially by means of games, to exercise the repression of fear and its expression, but during this part of his training other kinds of repression are more in evidence. In order to act as one of the aggregate to which he now belongs, the recruit has to repress any tendencies to individual action which would interfere, or are supposed by military tradition to interfere, with efficiency, and failure of these repressions has much to do with the production of war neurosis. Thus, a frequent factor in the production of war neurosis is the necessity for the restraint of the expression of sentiments of dislike or disrespect for those of superior rank, and these restraints become particularly trying when those who are disliked or despised are the instruments by which the many restrictions of military life are imposed or enforced.

When the soldier is brought into contact with actual warfare, a new set of repressions come into action. It may become necessary to control and inhibit the expressions of emotion consequent upon the dangers of warfare. In some persons, especially those already well schooled in such repression, this process seems to take place with no obvious conflict, but in many cases the necessity for such repression is continually present, while in a far larger number this necessity comes into existence as the result of strain, the presence of a conflict in this respect being in many cases the first symptom of his abnormal state that the soldier notices. He may notice that whereas at one time he was hardly aware of shelling or other incident of warfare, he now tends to duck his head or perform some other involuntary movement whenever the noise of a shell is heard, thus betraying the presence of a conflict. A state in which such a tendency persists and requires continual repression is one of the most frequent forms taken by the early stage of war neurosis.

When the soldier has been in the trenches for some time, a new necessity for repression may arise and may affect those who have not previously found it necessary to repress fears or apprehension, or in whom such repression, in so far as it has been present, has aroused no conflict. The soldier may undergo some particularly trying experience; some disgusting sight, or the death and mutilations of a friend or other experience may be so painful that it continually intrudes itself upon him while he unavailingly strives to banish it from his mind.

The last agency to be considered is that made up by sublimation and sidetracking. To the soldier these words may be strange, but not so the processes which they denote. By sublimation is meant a process in which an instinctive tendency, more or less fostered by experience, which would normally find expression in some kind of undesirable conduct, has its energy directed into a channel in which it comes to have a positive social value. By sidetracking we mean a process in which the energy so diverted acquires no special social value, but is altogether harmless, or at any rate less harmful to the welfare of the individual and community than that expression in which the energy would otherwise find its outlet.

One of the simplest and most frequent forms of sidetracking is the oath. The "strange oaths" or other forms of lurid language of the soldier are nothing but the relatively innocent means by which an outlet is given to superfluous energy. The form of energy which is perhaps most frequently thus released is that arising out of the repressions which form part of military training. Another form of sidetracking is to be found in the conviviality and relative freedom from restraint in certain directions which form so frequent an accompaniment to the life of the soldier.

One of the chief means of diverting spare energy, however this may be produced, takes the form of games and athletic competitions. Since these are of definite military value, they must be regarded as a means of sublimation. These exercises do not merely train the mind and body and thus add to the efficiency of the soldier, but they also have the most important function of utilizing spare energy, whether derived from the activity of repressed complexes or the product of some more healthy process.

A most important instrument of sublimation is to be found in the development of *esprit de corps*. There is thus produced a body of sentiments which contribute greatly to military efficiency, while at the same time they provide a most valuable means of sublimating energy which might otherwise work in the opposite direction.

In the old army the chief vehicle of *esprit de corps* was the regiment. The regular British soldier of the days before the war was above everything a member of the regiment. The honor and welfare of his regiment formed one of his chief interests, and the desire that he might do nothing to tarnish this honor or prejudice this welfare stood forth prominently among the means which enabled him to withstand trials and dangers.

This *esprit de corps* of the old army was chiefly bound up with the institution of "long service." A soldier spent years, including the most impressionable of his life, in one regiment, with the other members of which he came to have relations of comradeship which were even more efficacious as a protective against fear or other emotion than motives arising out of the more abstract sentiments of honor and duty.

These features of the process of military sublimation have been much changed in the more recent history of the British army, especially during the present war, but these changes have only modified the process and have not changed its essential character. They have affected the nature of the unit with which the *esprit de corps* is associated, the spirit embodied in the regiment or the company being now attached to the battalion or platoon, or other unit which has been brought into existence by the exigencies of warfare. The old spirit based on long years of comradeship has during the present war been replaced by one based on the sharing of common hardships and dangers.

More important than either *esprit de corps* in the strict sense, or the *cameraderie* which is so closely associated with it, is the special relation existing between officers and men. Anyone having much to do with those who have taken part in the fighting of the present war must have been struck by the extraordinary manner in which an officer, perhaps only just fresh from school, has come to stand in a relation to his men more nearly resembling that of father and son than any other kind of relationship. It seems clear that different battalions show the incidence of neurosis in very different degrees, and this is probably due more than anything else to the nature of the relations between officers and men by which the private soldier acquires towards his officer sentiments of duty and trust, while the officer is actuated, it may be dominated, by interest which could not be greater if those under his command were his own children.

This brief sketch of the aims and methods of military training has led me to distinguish three main processes—suggestion, repression and sublimation, while others of less importance in relation to neurosis are habituation and sidetracking. I can now consider how those different factors will affect officers and men respectively. The heightening of suggestibility, though probably an inevitable result of any kind of military training, is preëminently one which affects the private soldier. It is the private soldier especially who is submitted to prolonged mechanical drill and is continually subject to the commands of others, while the officer is not only less fully drilled, but the periods in which he is subject to the commands of others are relieved by other periods in which he is the dispenser of commands and orders.

Sublimation, on the other hand, has more effect on the officer. It is doubtful how far the honor and welfare of the regiment or other unit appeals to the private soldier in general, though it is perhaps almost if not quite as definite among the non-commissioned as among the commissioned officers of the old army. In the new army, it probably means little or nothing to the ordinary soldier, in whose case any sublimation due to military training has its source in comradeship or in his feelings of respect and duty towards his officers, and especially towards either his platoon- or company-commander. It is because the aggregate with which he acts is composed of men with whom he has shared hardships and dangers, with many of whom he has become comrade and friend, that this aggregate comes to have an influence upon him, while in other cases the relation towards his officer is more important. In each case, however, the result is the production of a state of dependence which works in the same direction as the factor of suggestibility already considered. The point of especial importance in relation to the incidence of neurosis is that the fact of comradeship to some extent, and far more the state of dependence on his officer, diminish the sentiment of responsibility and thus tend to enhance suggestibility or, perhaps more correctly, work in the same direction as suggestibility. In the case of the officer, on the other hand, the relation towards his men brings with it responsibilities which are perhaps more potent than any other element of his experience in determining the form taken by his nervous disorder, if he should break down. It is these responsibilities and other conditions associated with them which lead to his being so especially prone to suffer from the state of anxiety neurosis.

The third main factor, repression, is very important in relation to the incidence of different forms of neurosis in officers and men. The officer is driven by his position to repress the expression of emotion far more persistently than the private soldier. It is the special duty of the junior officer to set an example in this respect to his men, to encourage those who show signs of giving way. In the proper performance of this duty, it is essential that the officer shall appear calm and unconcerned in the midst of danger. The difficulty of keeping up this appearance after long continued strain or after some shock of warfare has lessened the power of control produces a state of persistent anxiety which is the most frequent and potent factor in the production of neurosis, and is especially important in determining the special form it takes. The private soldier has to think only or chiefly of himself; he has not to bear with him continually the thought that the lives of forty or fifty men are immediately, and of many more remotely, dependent on his success in controlling any expression of fear or apprehension.

A factor of minor importance, but one which is nevertheless worth mentioning here, is that the officer is less free to employ the picturesque or sulphurous language which is one of the instruments by which the Tommy finds a safety valve for repressed emotion.

The preceding argument has led us to the conclusions that of the three main agencies upon which the success of military training depends one, suggestion, is especially potent and prominent in the case of the private, while the other two, sublimation and repression, have by far the greatest effect in the case of the officer. One of the chief results of military training is to increase the suggestibility of the private, and this increased tendency in one direction is but little counteracted by sublimation or complicated by the necessity for vigorous repression. The factor of sublimation may even tend to enhance his dependence and suggestibility. In the case of the officer, any increase of suggestibility produced by his training is largely compensated by the necessity for individual and spontaneous action, while the *esprit de corps* and other means of sublimation only tend in many cases to heighten his sense of responsibility and thus add still another cause for his anxieties. There are many officers, both commissioned and non-commissioned, to whom the honor of the regiment or battalion is quite as potent as responsibility for the lives of others in producing the state of anxiety which forms the essential element in the production of their neurosis.

I have now considered how far the different forms of war neurosis can be traced to the influence of military training and the nature of military duties. It is gradually becoming apparent, however, that the conditions of military training and active service are very far from exhausting the factors by which war neurosis is produced. A large part, perhaps even a majority of the prolonged cases of functional nervous disorders which fill our hospitals, can be traced directly to circumstances which have come into being after some shock, illness, or perhaps only the ordinary process of leave, has removed the soldier from the actual scene of warfare. I have now to inquire how far the influence of military training and the nature of military duties assist in producing the neurosis of the hospital and the home.

Histories of cases of war neurosis show that officers after some shock or illness often suffer for a time from those symptoms which I have ascribed to suggestion, but whether owing to treatment or spontaneous change, these symptoms soon disappear. It may be that the failure to be content with a simple but crude solution of a conflict which satisfies the private soldier is due to superior education, but the nature of his training and duties also contribute to this result. If the disability were the unwitting outcome of a conflict between the instinct of self-preservation and a simple conception of military duty, it might suffice to be paralyzed or mute, but if the morbid state depends primarily upon sentiments of responsibility towards his military unit or his comrades, such a solution is not likely to satisfy his nature long. His conflict differs from that of the private soldier in that it is founded largely upon acquired experience rather than upon instinctive trends. It is more actively conscious than the process which has produced a paralysis or mutism. These disabilities fail altogether to touch the special anxieties which have taken the foremost place in the production of his illness.

In the state of weakened volition produced by shock or exhaustion it seems to the officer impossible that he will ever again be able to exert the vigor of control and initiative which alone enabled him to maintain the upper hand in the conflict of the trenches, and with this realization, the former conflict is replaced by one still more painful and enervating, in which sentiments of duty struggle ineffectually against a conviction of unfitness.

In this conflict military training and duty take a most important place. There are many officers whose conflict would be solved or would never have existed, if it were merely a matter of personal safety. It is the knowledge, born of long experience, that the honor of their military unit and the safety of their comrades depend on their efficiency which forms in many cases by far the most potent factor in the production or maintenance of anxiety states. To the private soldier, devoid of such responsibilities, the mere solicitude about his safety forms a less potent motive for conflict, and one which is more easily solved. Once the disability due to suggestion has disappeared spontaneously or by treatment, there may be no obvious conflict left. The instinct of self-preservation, to which his disability has been essentially due, will of course still be there, ready to reassert itself if the occasion arise, but any conscious conflict is so readily solved in accordance with obvious standards of social conduct that there is no opening for the occurrence of any state of anxiety sufficiently profound to act as the basis of neurosis.

The conclusion reached in the preceding pages is that the private soldier is especially apt to succumb to that form of neurosis which closely resembles the effects produced by hypnotism or other form of suggestion, because his military training has been of a kind to enhance his suggestibility. The officer, on the other hand, is less prone to this form of neurosis and falls a victim to it only when there is some organic injury which acts as a continuous source of suggestion. On the other hand the officer is especially liable to anxiety neurosis, because the nature of his duties especially puts him into positions of responsibility which produce or accentuate mental conflicts set up by repression, thus producing states of anxiety, the form taken by his nervous disorder. It will now be well to inquire whether this relation of military training and duties to the form of neurosis points the way to any practical conclusions. Several aspects may be considered here: nomenclature, prophylaxis, and treatment.

Nomenclature

The nomenclature of functional nervous disorders is at present in a very unsatisfactory state. Cases of paralysis, contracture, anaesthesia or convulsive seizures, which provide the most striking manifestations of functional nervous disorder, were once universally known under the name of hysteria, because they seemed to be especially apt to affect women. The words "hysteria" and "hysterical" acquired a meaning which made their use inconvenient for many purposes, and they were gradually replaced in practice by the term "functional," at any rate in this country. This term, however, has so wide an application as to make it of little scientific or practical value. Used originally as a means of avoiding the term hysteria, it has become a label for a large number of morbid states differing widely from one another in nature, and calling for very different forms of treatment.

Another functional syndrome which is widely recognized is neurasthenia. Even before the war, however, this term was being used in so wide a sense that it was becoming every year of less value, and it has now lost the last remnants of any scientific value it once possessed by its adoption as the official designation of the army for all forms of functional nervous disorder. A third term, psychasthenia, has been used in most textbooks of medicine, but in a very unsatisfactory sense. The cases usually called neurasthenia present signs of mental as well as of bodily enfeeblement, and if the term "psychasthenia" had been used for those cases in which mental exhaustion was especially prominent, there might have been some sense in its use. The term has been used, however, for cases of obsession, phobia and compulsion in which there is often no sign of general mental exhaustion, cases differing from the so-called neurasthenia in the special direction taken by mental energy rather than in any defect in its amount. All the old terms being thus unsatisfactory for one reason or another, it becomes necessary to find a wholly new nomenclature.

Babinski* has recently proposed pithiatism, a word derived from the Greek term for persuasion, as a substitute for hysteria. This term has been especially chosen to distinguish the cases formerly called hysteria from other similar states on which persuasion has no effect. Babinski has been influenced in his choice of the word by the need for a term to distinguish functional from organic paralyses, especially from the reflex paralysis in which Babinski is especially interested. Through this special interest he has been led to ignore the large group of functional nervous disorders which are especially open to the influence of persuasion, but yet differ fundamentally in nature from the cases which the term pithiatism is especially intended to denote. It is also unusual, and hardly satisfactory, to denote a disease on the basis of a feature of its therapy. It will be much more satisfactory if it is possible to find a term based on the etiological rather than the therapeutical aspect of the syndrome.

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* See J. Babinski and J. Froment, Hysteria or Pithiatism, and Reflex Nervous Disorders. London: University of London Press, 1918.

One term of this kind which has been used by Freud and his followers is "conversion neurosis." The use of this term is based on a definite theory, according to which the paralysis or other affection is held to be the outward manifestation of some underlying unconscious tendency which thus finds a more or less dramatic expression. The paralysis, contracture or convulsive seizure is regarded as the product of a process of conversion whereby the energy of some unconscious process is transformed into, and finds expression in, one or more of these symptoms. Partly because the term implies a theory which all will not be ready to accept, but still more because there are other pathological states to which the term would be equally appropriate, it is improbable that this term will find general acceptance. Since it is generally conceded that these functional paralyses, contractures and other manifestations closely resemble, if they be not identical with, the products of suggestion, it would seem that suggestion neurosis* would be an appropriate term. If I am right in my view that the special prevalence of these states in the private soldier is due to his enhanced suggestibility, this term becomes still more appropriate. The term has the advantage that its meaning is at once obvious and does not require recourse to the dictionary. Suggestion, being a common English word, is very unlikely to acquire the inconvenient associations which have become attached to hysteria. Suggestion neurosis not only carries its meaning on the surface, but this meaning is one which points directly to an essential feature of the state it denotes.

For the other chief form of functional nervous disorder no more appropriate term can be found than that which I have used in this report. The meaning of anxiety neurosis is also at once apparent. It indicates in direct fashion that anxiety is both the main factor in causation and at the same time one of the leading symptoms. The only disadvantage of the term is that it has been used by Freud and his followers* in a somewhat narrower sense than that given to it in this report and in the work of MacCurdy† and other writers on war neurosis. The Freudian usage has, however, had so little effect on the general body of medical practice that this disadvantage is not very great, and the usage now proposed only involves such widening of the connotation of the term as we might expect to be the result of the experience derived from the war.

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* Suggestion is here used as the name for the process by which the hypnotic state is produced.

Anxiety neurosis is so often accompanied by repression, and so many of its symptoms can be ascribed to this etiological factor, that repression neurosis might seem to afford an alternative term. There are, however, many cases of anxiety neurosis in which repression is not present or is of little importance. In many cases even the opposed process of dwelling too exclusively on the causes of anxiety is in action, so that the use of repression neurosis would make still another term necessary. It will therefore be more convenient to speak of anxiety neurosis with or without repression, although in some cases repression is so prominent as to make repression neurosis a useful term. If this term is used, however, it must be remembered that the state denoted is only one variety of anxiety neurosis.

Prophylaxis

If there is any truth in the foregoing scheme of the influence of military training and duties in the production of the different forms of war neurosis, it is evident that much might be done in the way of prevention. If the special tendency of the private soldier to suffer from suggestion neurosis is due to the effect of military training in heightening his suggestibility, it will follow that this training should be carefully reviewed with the aim of modifying those of its features which tend especially to produce this result. It is probable that the necessary changes would correspond closely with those already made necessary by the nature of modern warfare. The encouragement of independence and the less mechanical training which is following the multiplication of the means of warfare should have as one of their consequences a lessening of the tendency to heighten suggestibility, and should therefore diminish the occurrence of suggestion neurosis.

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* See *Proceedings of the Royal Society of Medicine*, vol. 11, 1918, Section of Psychiatry, p. 19-20.

† *Psychiatric Bulletin*, Utica, N. Y., State Hospitals Press, vol. 2, p. 243, July 1917.

Much could be done in the prevention of anxiety neurosis if the commanding officer and the battalion medical officer were alive to the conditions upon which this state depends. If they worked together to utilize this knowledge, many a young subaltern and non-commissioned officer would be saved during the early stages of his disorder by rest or appropriate change of occupation and brought back to health and peace of mind. Such measures are adopted at the present time, but often not until anxiety has produced a state of obvious unfitness, so that the period of rest or change prescribed is quite inadequate to restore stability. If the nature and causation of anxiety neurosis were more fully understood, it would be possible to intervene at an earlier stage and save many a valuable career, for the victims of this form of neurosis often suffer through excess of zeal and too heavy a sense of responsibility and are likely to be the most valuable officers.

Another line in which much might be done towards the prevention of anxiety neurosis is suggested by the part which repression takes in the production of this state. If the soldier were taught the dangers of repression from the outset of his career, he would be less likely to adopt a course which may only postpone a breakdown to make it far more severe whenever it comes. The influence of repression in the production and maintenance of anxiety neurosis suggests that from the beginning of his training the soldier should be encouraged boldly to face in imagination the dangers and horrors which lie before him. A most successful officer has told me how in the early days of the war he encouraged his men to "think horribly," to accustom themselves in imagination to the utmost rigors and horrors of warfare, with the result that they were highly successful in bearing the exceptional trials of the Gallipoli campaign. It is difficult to gauge how far this success was due to the course advised and how far to other conditions arising out of the personality of the officer who advised it, but the experience suggests that much might be done in this direction. We can at least be sure that a soldier who steadfastly refuses to face in imagination the trials that lie before him is very unlikely to cope successfully with the reality. Many of those who pass unscathed through modern warfare do so because of the sluggishness of their imaginations, but if imagination is active and powerful, it is probably far better to allow it to play around the trials and dangers of warfare than to carry out a prolonged system of repression by which morbid energy may be stored so as to form a kind of dump ready to explode on the occurrence of some mental shock or bodily illness.

Treatment

If the argument of this report is sound, that the cases of functional nervous disorder hitherto labeled hysteria are produced by suggestion and depend on the enhanced suggestibility of the private soldier, it might seem at first sight the obvious course to make use of this heightened suggestibility in the treatment, and to use suggestion, either with or without the production of hypnotic state. If, however, suggestion be used in the ordinary crude way to remove symptoms, this line of treatment will only tend still further to heighten the suggestibility of the patient and to increase the tendency to similar disorders whenever he returns to the field. If at the time that the symptoms are removed suggestions are given against the occurrence of similar disabilities in the future, more could be said for this line of treatment, but this of course would not affect the heightened suggestibility which is the root of the evil.

The argument of this report points rather to a course in which treatment should be directed to lessen the suggestibility by a process of reeducation. This process should be so designed as to make the soldier understand the nature of the disorder which has afflicted him. He should be made to realize the essentially mental basis of his trouble and be thus put into a position in which, even if the disability recurs, he will not long be satisfied with it as a solution of the situation. This line of treatment has the disadvantage that it sometimes succeeds in doing away with the paralysis or other symptoms only to replace the physical disability by a state of anxiety; but a soldier in whom the conflict between the instinct of self-preservation and duty is so pronounced as to lead to this result is very unlikely to show any more real success if treated by suggestion. Here, however, as in so many other departments of psychotherapy in connection with the war, we are hampered by our almost total ignorance concerning the after-history of soldiers who have been subjected to different modes of treatment. It is possible that there are sufferers from suggestion neurosis who are capable of long and valuable service if the symptoms due to suggestion are treated by means similar to those by which they have been produced.

In cases of anxiety neurosis the lines of causation considered in this report offer less help in treatment than in prevention. The knowledge of the process by which his state has been produced often greatly helps a patient, especially in removing or diminishing depression, or even shame, consequent upon failure. If he can be brought to see that his illness is the outcome of definite agencies over which he has had no control, or has been due to excess rather than defect in certain good qualities, the symptoms may be greatly relieved and the patient set upon a path which, if the exigencies of military service allow, may enable him again to perform his military duties. The knowledge of causation set forth in this report is useful in thus providing a groundwork for the process of reeducation.

REGISTRATION OF THE FEEBLEMINDED*

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Community control of the feebleminded involves the progressive steps of identification, registration, instruction, supervision, and segregation—and the second in importance of these is registration. Without it, no program for community control of the feebleminded will advance very far.

I shall not take the time to dwell upon the need of more effective measures to control feeblemindedness. I take it for granted that we all have come long since to a realization of that need. If anything were needed to supplement our experience along this line in civil life, it is furnished by the rejection of more than 21,000 men from the Army on account of nervous and mental disorders of which number practically one third or 7,000 were feebleminded.

As one looks over the history of efforts to control feeblemindedness he is struck by the unanimity with which authorities urge registration as one of the most essential steps. Practically everyone regards registration or a continuing census next in importance to identification. I should not in this meeting expect any dissent from the general proposition that next in urgency to finding out who the feebleminded are, is the need of making a list of them, their whereabouts, and their histories, and keeping the list up to date.

Naturally the question arises, If registration is so important and there is such a unanimity of opinion about it, why isn't it more frequently done? I confess that I do not know. Certain it is that this has been one of the most neglected steps in community control of the feebleminded. I wonder if our failure to make progress in any large and continuous way is not due to a considerable extent to this neglect? Will we ever make substantial and permanent progress except by making registration a part of our program?

In fact, lack of accurate knowledge about the problem of feeblemindedness has been the great stumbling block in the way of efforts toward dealing with it effectively. As Dr. Walter E. Fernald has said, "The one great obstacle to effective prevention of feeblemindedness is the lack of definite, precise knowledge. . . . We do not even know the exact number of the feebleminded."

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* Read before the Mental Hygiene Section of the National Conference of Social Work, Kansas City, May 16, 1918. General topic of the section meeting was "Steps Necessary in Community Control of the Feebleminded."

Naturally the first thing that a legislature or other public body wants to know when it is asked to spend money to provide for the training, supervision or segregation of the feebleminded is, How many do you want to provide for? This is the one question which the average community or state cannot answer. It is a question that must be answered for legislatures and communities are moved to action by facts, not generalities and guesses.

But a census is needed not only to stimulate state or community action but as the basis for the program which it is desired to carry out. A census and classification of all the feebleminded in a state, with information as to their family histories and environment, will show not only the number but also the character of those requiring institutional care and make possible an intelligent decision as to the kind and size of the institutions needed. It will point the way to intelligent supervision and training of the defectives for whom institutional custody is not necessary. It is not sound public policy to begin expensive building projects without knowing how many defectives are to be housed. And it is courting certain failure to place mentally defective persons in any large number under private supervision, even under the care of relatives, unless the persons registered are accessible to the state or community authorities so that their care and training can be supervised and certain standards maintained.

One might naturally expect to find light on the number of feebleminded persons in the country by examining the figures of the Federal census, but those figures are so incomplete that they are practically valueless.

Various special attempts have been made to enumerate the defectives in given areas, but none has ever been a complete census. The surveys of the British Royal Commission on the Care and Control of the Feebleminded (appointed by the late King Edward VII to make a study of feeblemindedness in the British Isles), the survey in Nassau County, New York, and surveys, studies and enumerations in various states and in some of the large cities of the United States are the most notable examples of these attempts. But in no state in this country, so far as my information goes, does there exist machinery for an adequate and continuous registration of the feebleminded. Such a system, it seems to me, is a prerequisite to intelligent action and progress.

The evidence in favor of segregation as an essential step in controlling feeblemindedness is voluminous. It would scarcely be possible even to summarize all of it. I should like to mention a few of the sources from which recommendations and knowledge on the subject emanate.

The study made by the British Royal Commission is generally regarded as the best from the standpoint of scientific method and thoroughness of any survey of its kind ever made. The Commission's findings were incorporated into a report consisting of seven volumes. It recommended that "if the mentally defective are to be properly considered and protected as such, it is necessary to ascertain who they are and where they are and to bring them into relation with the local authority."

Largely as a result of this Commission's inquiry and report was passed the British Mental Deficiency Act of 1913, which has been referred to as "the most important measure of social reform and social justice of modern times." In this law the registration of the feebleminded is made largely a local affair, although provision is made for sending copies of the certificates of feeblemindedness issued by the local authorities to a central body in London, if required.

In Canada, Dr. Helen MacMurchy, Inspector of Auxiliary Classes for Ontario, writes that "the powers conferred upon the school authorities by the Education Act, the Compulsory Education Act, and the Auxiliary Classes Act, enable them to make a complete register of all children of school age under their jurisdiction, include all children who may be unable to reach the school or to benefit by the instruction given in the ordinary classes."

The Public Health Committee of the New York Academy of Medicine in a survey of its activities from 1911 to 1916 recommended "a permanent bureau of life records and that the criminal feebleminded should be referred by the courts to a State Board." In 1915 this Public Health Committee recommended to the Constitutional Convention the establishment of a State Board "with power to register all of the mentally deficient of the State."

The report of the State Board of Charities of Virginia to the General Assembly of 1916, based on a special inquiry, recommended that "the State Board be empowered to have charge of the the registration of the mentally defective persons of the commonwealth."

A special commission studying the subject of segregation and care of the feebleminded in Pennsylvania also recommended registration as an essential step.

The National Committee for Mental Hygiene, in its recommendations to the Commission on Provision for the Feebleminded in Kentucky, said:

"For the ultimate solution of the problem, registration of all the feebleminded, with life-long supervision either in the community or in the institution, is necessary. A complete register will be a matter of gradual growth and development, but will be made possible in time as the agencies in the public school and elsewhere in the community are better able to identify early those who are defective. At one time or another practically every feebleminded child in the state comes in contact with some organized agency of the state—the school, the court, the children's homes, the charitable societies—and if at this contact provision for identification is provided (and in all of these agencies the problem is of such magnitude as to warrant such provision) registration becomes a simple matter. The registration of all the adult feebleminded now in the state is probably not possible; but such a registration is not essential. If the State of Kentucky will provide adequate care for those now known and identified in the community, and will at the same time increase her facilities for early diagnosis and register year by year those defective children who, as they advance toward adolescence, come in contact with her social agencies at one point or another, the State of Kentucky will steadily gain in her control of the problem of feeblemindedness as it exists within her borders."

In New York State, the Hospital Development Commission, created by the 1917 legislature, recently completed the first year of its study of feeblemindedness and insanity. One of its chief recommendations in regard to the feebleminded is that the state should "make a census as complete as possible of all the feebleminded in the state, obtaining all possible light on their family histories and surroundings."

A law has just been passed in New York creating a new State Commission to administer the law in relation to the feebleminded. Its duties are specified in part as follows:

"Immediately on its organization plan a census of all persons in the State who are feebleminded persons; . . . and for this purpose the education department and any other state agency shall furnish such aid and information, within its power, as the Commission may require. Prepare and keep a record of all feebleminded persons in the state and provide accommodations for all such as require care and treatment in suitable institutions."

A survey of mental disorders in Nassau County, New York, from July to October 1916, by the National Committee for Mental Hygiene and the Rockefeller Foundation, with the United States Public Health Service cooperating, has been compared as to scientific method and thoroughness with the survey of the British Royal Commission, although the inquiry was made on a broader sociological basis. To quote from the report:

"The principal question raised is not, What is the percentage of 'insane' or 'feebleminded,' or 'mentally defective' persons in the population? But rather, What instances of social maladjustment, sufficiently marked to have become the concern of public authorities, are, upon investigation, to be attributed mainly or in large measure to mental disorders? Thus the main object of the survey was to study the nature of the relationship between social maladjustments and mental disorders. Accordingly two independent systems of classifications were adopted—a medical and a sociological one."

This survey revealed a rather striking amount of social maladjustment due to mental disorders. Although the survey differs somewhat in object and method from other surveys of its kind, the recommendations growing out of it are equally striking as regards registration. They emphasize the need of registration of "instances of maladjustments sufficiently marked to come to the notice" of various public authorities. By continuing, revising and refining the registry from time to time in the light of new data, it is anticipated that "after several years' development such a register will show that the bulk of all crime, vice, dependency and other maladjustments in a given commonwealth is attributable to a comparatively small fraction of the population."

In 1915 the legislature of Missouri created a Children's Code Commission to Codify the laws of the state relating to the welfare of children. J. E. Wallace Wallin, as chairman of its Committee on Defective Children, made as one of his seven recommendations to the Commission the creation of a State Bureau of Psychological Diagnosis to which should be reported the names of suspected feebleminded children. The Commission made a general recommendation for state-wide registration of feebleminded children from public and parochial schools to be sent to a state agency.

Dr. Walter E. Cornell, former Director of Medical Inspection of Public Schools, Philadelphia, and Chief Examiner of the House of Detention and Juvenile Courts of Philadelphia, in a paper which he read before the National Conference of Charities and Correction in Baltimore in 1915, advised:

"The registration of all feebleminded, both those at large and those in institutions is one of the most important steps looking toward the reduction of their number. It furnishes the necessary medical testimony to the court when the feebleminded are before the bar in later years on charges of vagrancy or delinquency. It also gives us the information concerning the actual number of the feebleminded—a necessary preliminary to adequate provision by the state for custodial institutions. The matter of registration in the large cities at least is not difficult in certainly 95 per cent of the cases. Neither is it expensive. The writer handles all the cases of the Philadelphia Juvenile Court, the Bureau of Compulsory Education, the Children's Aid Society, the Society for the Prevention of Cruelty to Children and the Philadelphia Children's Bureau. There are in the Philadelphia public schools, in round numbers, 400 definitely feebleminded children, and 3,500 borderline cases. These latter are not at the present time officially examined, but it could readily be done in the Division of School Medical Inspection at a cost of certainly not more than $3,000 per year. The sum of $10,000 per year would register every feebleminded child in Philadelphia, for every public and private agency, all expenses of medical and clerical service included. . . . The registration, of course, would have to be under the sanction of the courts or of some official designated by the legislature."

Indiana is rather an exception to the rule about registration, for a number of years ago the state took steps to provide limited registration, the results of which have heretofore been the subject of papers by Amos W. Butler, Secretary of the Indiana Board of Charities, and Ernest P. Bicknell, a former secretary. My understanding is that this was largely institutional registration. The institutions made regular reports as to the persons admitted to them so that officials and social organizations working in the various communities had in their possession data about families in which feeblemindedness existed. It is, of course, of enormous advantage to know of these prepotent families so that steps can be taken to deal with them.

As Dr. Fernald has said, "It is possible that a real eugenics survey of a given locality might show that 80 per cent of the feeblemindedness in that locality was contributed by 5 per cent of the families in that community."

The importance of identifying and recording these prepotent families as a preliminary to doing something about them is obvious. Here perhaps is the finest opportunity for intensive and effective work in checking feeblemindedness.

Although I am not scheduled to speak on identification or diagnosis at this meeting and some one else *is*, I cannot refrain from saying just a word about it because of its important bearing on the subject of registration. I feel very earnestly that registration should be made only after definite and accurate diagnosis, based on a well-considered and established standard of normality, as near as may be.

Josh Billings said it was better not to know so much than to "know too many things that ain't so." I should rather not register so many feebleminded than to register many who are not feebleminded.

Our standards and methods of deciding about feeblemindedness should be in accord with the best thought and scientific knowledge of the time, but the details and the terminology of the process should not be described to the general public in such ultra-scientific and high-sounding terms that the public will be unsympathetic, if not skeptical. Dr. Fernald uses the Binet (age basis) tests or other standard tests and modifications, plus a study of family history, economic efficiency, and moral reactions. If three of these show subnormality below the accepted standard the person is considered feebleminded.*

Of course the neglect to register the feebleminded has been attributed in part to the fact that no practical and effective method has been presented. But it has also been due partly to the fact that investigators were too easily frightened by the apparent size of the job. Personally, I have a strong feeling that they were unnecessarily frightened—that it is not so hard as it appears, that it would not require as extensive machinery and as much time as some authorities have thought, and that if the machinery now maintained by public and private organizations could be fully utilized, comparatively little new machinery would be necessary.

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* Standardized Fields of Inquiry for Clinical Studies of Borderline Defectives. By Walter E. Fernald, M. D. MENTAL HYGIENE, v. 1, p. 211-34, April 1917.

In a word, if some existing state body or a newly created state body could be charged with the duty of collecting, classifying and coordinating the data that the schools, courts, reformatories and local officials and organizations throughout the community already have on hand or could obtain with comparatively little effort, we should soon be a long way on the road toward a census of the great bulk of the feebleminded—certainly as many as could be promptly provided for. By continuing to collect, classify and revise these data as provision is made for cases already listed and as new cases are discovered in the community, we should soon have a basis of accurate knowledge on which to build programs and take intelligent action.

If efforts were concentrated for a few years merely on discovering and listing the defective children, disregarding adults, the results in a generation or two would be far-reaching.

There are four places in which many of the feebleminded can be detected early in life—the home, school, juvenile court, and the reformatory. Of these, the school is the most important so far as registration is concerned. All children do or should pass through the schools. Here their condition should be diagnosed and registered, and instruction suited to their capabilities provided. Or, if they are to require supervision or segregation for life this can be provided before they have gone out into the community and become criminal, immoral, diseased, paupers or ne'er-do-wells.

The compulsory education law in each state should require the registration of every child of school age, including defectives. When children are not found attending school because of mental defect, their diagnosis and social standing should be known to the school authorities and recorded for the use of public and private organizations dealing with the feebleminded. Unfortunately in many states the compulsory education law does not require children who cannot profit mentally to attend school. The law should be amended to bring all children of school age within its purview. If a child cannot profit in a regular or special class, he should be in a state institution for training and protection, or his training and supervision at home or elsewhere should be maintained at a certain standard, and the state or community should have officers to see that that standard is maintained.

If ungraded classes for backward and defective children were more general, as they are likely to become within the next few years, and if we had nothing more than the registration of the members of and candidates for these classes, we would account for a vast number of the morons and imbeciles who form such a large part of the feebleminded now without protection in the community.

Starting then with the school system as a nucleus of a mechanism to keep an accurate and continuing record of the feebleminded and to report it to a central state authority at intervals, we might rely upon the following organizations and agencies acting cooperatively with the mental specialists to make a substantial census of the great bulk of cases in the community:

1. Public schools, local boards of education and the State Departments of Education in the various states.
2. Juvenile and adult courts, especially those which have facilities for mental examination of the cases brought before them.
3. Probation officers.
4. Jails, reformatories, orphanages, and all other private and public charitable, reformatory and correctional institutions.
5. Commissioners of charities, superintendents and overseers of the poor, superintendents of almshouses and all other poor-law officials.
6. Physicians in general practice, and more especially those engaged in the specialties of neurology and psychiatry.
7. Charity organization societies, and other relief and social agencies.
8. Societies for the prevention of cruelty to children.
9. Clinics and hospitals (especially the out-patient departments of institutions for mental diseases), and city and charity hospitals.
10. Lodging-houses and work-houses that shelter vagrants.
11. State and national mental hygiene societies and local committees.
12. County agents and agencies for dependent children.
13. Institutions for the care of the feebleminded, insane and epileptic should report and register all cases sent to them and all who are candidates but who cannot be accommodated and are placed on the waiting lists.

The records thus obtained should be filed with a central governmental agency and also be made available for social workers, school authorities, and other agencies. It would prove of great value in the solution of the individual problems which the feebleminded constantly present.

"This alone," as Dr. Fernald says,* "would mean a great saving in time, effort and money. Once a person was adjudged feebleminded, a permanent accessible record would be made.

"This continuing census and registration of the feebleminded would make possible regular visitation of each defective who needs oversight by the trained social worker or by the local representative of the central bureau. The reports of these visitors, covering the life histories and the family histories of many cases, would soon constitute an invaluable treasury of information as a basis for scientific research and study in the search for practical methods of prevention. The official visitor would advise the parents as to the care and management of the defective and would have opportunity to inform the family, the local officials and the community generally as to the hereditary nature and the peculiar dangers of feeblemindedness.

"The registration of every feebleminded person, and the regular visitations, especially of children of school age, would make it possible to inform the parents of the condition of the child, of the necessity of the life-long supervision, and of the possible need of future segregation. . . . Sooner or later the parents will probably be willing to allow their child to be cared for and trained in the institution. In suitable cases parents who are not willing may be allowed to have the custody of their child, with the understanding that he shall be properly cared for and protected during his life, that he shall not be allowed to become immoral or criminal, and that he shall be prevented from parenthood. Whenever the parents and friends are unwilling or incapable of performing these duties, the law should provide that he shall be forcibly placed in an institution or otherwise safeguarded. The local representatives of this central bureau would officially serve as advisers and sponsors for pupils graduated from the special school classes, for court cases under probation and observation and for institution inmates at home on visit or on trial."

If such a system as this could be established in the various states, with a reasonable uniformity assured through Federal help extended by the Public Health Service or through the coordinating influence of some national organization for mental hygiene, the results in a few years might easily take us a long way on the road to a solution of the problem of controlling feeblemindedness and really mark a new era in dealing with it.

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* The Feebleminded. By Walter E. Fernald, M. D. *Educational Review*, v. 54, p. 118–27, September, 1917.

The schools would be compensated for their efforts by the incubus that would be lifted from their regular classes and to some extent from their ungraded classes. Relief organizations would quickly feel their burden lightened. So, in fact, would all social agencies. Reformatories, almshouses and other institutions would be in a position to do better by their normal inmates if relieved of their abnormals.

And how much the feebleminded themselves would gain in treatment, training and public understanding by such a system of registration!

I cannot furnish a fully worked out form of registration with which to carry out the system here under discussion. Undoubtedly this could only grow out of actual experience for some time in meeting the various problems, complications and questions as they arise in the attempt to make a registration. The methods of selecting and recording pupils for ungraded classes in the public schools might throw light on the broader problem.

I have ventured to draft a tentative form of registration which includes some of the main points which it seems to me should be covered in such a system. In it I have attempted to make a registration form to indicate the essential medical, psychological, and sociological data and yet not be too complicated and lengthy for practical administrative purposes. The card is as follows:

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REGISTER OF THE FEEBLEMINDED
in

Town or City..
County..
State...

Name..
P. O. Address (Street and Number)...
Age........................ Sex................ Nationality..............
Birthplace........................... Married............ Children..........

Diagnosis:
Idiot........ Imbecile............ Moron............ Border Line.........
Mental Age................
By whom diagnosed: ....of
P. O. ....on
Date ....

Prognosis:
....

Characteristics:
Dull.......... Stupid.......... Cruel.......... Boisterous............
Wayward............

Habits:
Alcoholic............ Drug Addict............ Sex Abnormality............

Physical Defects:
Syphilitic..... Epileptic..... Paralytic...... Tuberculous..............
Crippled....... Eye...... Ear........ Nose and Throat..............
Speech Defects........................ Other Defects.......................

If Woman, how many children borne..............................
How many living..
Any illegitimate..
Miscarriages..

School Record:
No. of years in school...................... Grade.........................
No. of years behind grade...........................

Record of Occupation:
Employed: Regularly...................... Irregularly..................
Not ever employed..................... Kind of employment.............
Earning capacity......................... Self supporting ....

Social Contacts and Conflicts:
Ever received public support or relief.........................
(Give extent and time)..................................
Ever been in prison.......... reformatory.......... almshouse..........
or other institution ....
(Give length of time and details)...
Ever been in Juvenile Court....................
Ever been on probation....................
(Give circumstances)..

Facts About Parents of Person Reported:
Nationality of father.................... His mental status................
Nationality of mother................... Her mental status................
Were parents married................... Are parents living now............
Additional data...

This report made by...
P. O. Address...
Name of organization...
Position...

PSYCHIATRIC AIMS IN THE FIELD OF CRIMINOLOGY

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THE widespread recognition which medicine has come to gain as an agency of social hygiene and social amelioration carries with it new opportunities and new responsibilities for the physician. It renders imperative the physician's emancipation from the individualistic tradition of aloofness which has gained control of the profession with the passing of the family doctor and of the intimate personal relationships that could not survive under modern conditions of specialization and pace. The relatively ineffectual cultivation of fields of endeavor, now seen to be the legitimate province of the physician on the part of socially conscious but medically untrained workers, has resulted necessarily from the physician's too narrow conception in the past of his own sphere of action. Fortunately there is setting in a healthy reaction to this conservatism, and its champions are naturally to be found among those whose chief professional interest lies within the field of mental medicine. With the growth of the extra-asylum tendency in psychiatry, new and vital contacts are being made between this branch of medicine and the social sciences, and our former pride in the humaneness and efficiency to be secured by the asylum treatment of the insane is not nearly so aggressive today as it was in former days. Like prisons and jails and poorhouses, the old type of asylum may justly be looked upon as an anomaly in a truly civilized community, and as evidence of failure rather than of efficiency in social hygiene and social control.

Today, the psychiatrist, with a liberal conception of the scope of mental medicine, cannot exclude from his professional purview those acute symptoms of social maladjustment and social distress which take the form of insanity, feeblemindedness, criminality, prostitution and pauperism. His interest is continually being challenged on the one hand by questions relating to heredity, education, industrial and economic conditions, home, school, playground and workshop and, on the other hand, by those artificial social provisions which had to be devised to take care of the constant and growing stream of failures: the reformatory, the prison, the almshouse, the pauper and inebriate colony, the municipal lodging house, etc. The progressive economist, sociologist, criminologist or social worker, is no longer content to attribute the social unrest and distress that he meets on every hand either to supernatural causes or to innate perversity, but seeks the explanation in antecedent organic and environmental phenomena, and in the course of his search, he frequently comes upon phenomena lying well within the sphere of mental medicine.

It is, therefore, not at all strange that the late Prof. Carleton Parker, unquestionably one of the wisest economic thinkers of the present generation, should have reached the conclusion after an intimate study of the I. W. W. that the inception and feverish growth of this movement was due to a neglect of the fundamental truths of social psychology. A "reactive psychosis" he terms the I. W. W. movement, analogous to the reactive psychoses that the older brutalizing and inhuman prison régime provoked and that was also reflected in the wild outbursts of the insane under the system of restraint of the old type of asylum.

Now that social scientists themselves have perceived and pointed out to the psychiatrists the contribution that the latter can make to the solution of essentially social problems, the time is opportune for psychiatrists to respond to the call by recognizing the inseparable social aspects of their own material, both on the side of causation and that of consequences. To illustrate:—a family group which for twenty years has been the object of almost constant attention on the part of various charitable and relief agencies, is found today to be no nearer adequate adjustment than at the beginning; on the contrary, of the ten children resulting from the union of the couple at the head of this family group, some of the girls have already been committed as delinquent, and some of the boys have found their way into reformatory and penal institutions. The group finally comes to the attention of a wide-awake social worker, who is not satisfied with mere patchwork. The psychiatrist is called in to define the problem and he finds at the head of the family an epileptic-defective mother and a feeble-minded chronic alcoholic father. Examination of the children reveals a wide distribution of mental deficiency, malnutrition and profound neglect. The problem of this family becomes at once a psychiatric problem, and the failure of relief agencies to deal with it successfully through all these years is seen to be the result of the neglect of the psychiatric issues involved. Or take the case of a true paranoiac who for over a quarter of a century has been living in strict seclusion in a city basement in order to escape the fancied persecutions of various government agents who were after his inventions, etc. His true difficulty all this time was entirely ignored by the various social agencies to whom he complained that he was the victim of a widespread conspiracy, until the community was aroused by the shocking discovery that he had raped a number of school girls in the neighborhood. In his suspiciousness, and avoidance of grown-ups, he came to confide exclusively in the young children of the neighborhood whom he employed on various errands and liberally rewarded with pennies. This intimacy with the little girls of the neighborhood involving, as it did, their possibly permanent moral injury, was not discovered until it had assumed a very dangerous aspect. The police and the cumbersome machinery of the criminal law were then set into motion with much effort and expense on the part of society and the man was sent to state prison, there to be recognized, for the first time, as a psychiatric problem, the timely diagnosis of which would have prevented so much human woe.

Clinical studies of large numbers of repeated offenders, vagrants, paupers, prostitutes, etc., have brought to light a fact that might have been anticipated—that back of these perverted behavior expressions lie causes that rightly call for the attention of the psychiatrist, and that in an astonishingly large percentage of these cases, psychiatric issues are the chief determinants involved.

But for a proper recognition and appreciation of these issues, a much broader conception of the nature and meaning of psychiatry must gain currency than that which obtains in legal and juristic circles and which, unfortunately, has been fostered to a considerable extent by the expert psychiatric witness. While we readily enough concede the principle that sanity and insanity, like health and disease, are not strictly delineable contrasts when our relationship is that of physician and patient, we take alarm at this thought when the question of mental disease arises in connection with one accused of crime. Many of us are still willing to stake our reputations as physicians on the witness stand when engaged by an obliging prosecuting attorney to assist him in proving the responsibility of the accused for his act. Although we are disposed to grant that there might be some mental abnormality in the case, we are quite certain that his madness had not progressed far enough to exclude a knowledge of the difference between right and wrong. The law, dealing as it does with the problem of crime in a wholly impersonal manner and concerned as it is with the administration of the criminal act rather than with the understanding of the criminal back of the act, is satisfied with such conception of mental disease. In the legal mythology, an offender is either a free rational agent, acting deliberately and in full consciousness of consequences, or he is demonstrably demented. The psychiatrist's unprotesting participation in this sham only helps to keep alive the most obsolete methods in the social control of the problem of crime. It gives dignity to the fallacious assumption that the law and its processes are not called upon to justify themselves by results, and stops inquiry into the underlying causes of crime, thereby assisting in the substitution of mere routine administration of the problem for rational concerted attempts at its solution.

Let us look for a moment at this question of responsibility. Whence this imperative need for a nice exact estimation of the degree of responsibility? If we start from the optimistic assumption that the object of the criminal process is, or ought to be, the fullest safeguarding of the social order, with perhaps the least incidental violence to the individual—and we fail to see how its ultimate object can be anything but that—why this splitting of hairs over the precise definition of responsibility? A man is arrested for a crime. The fact is established that he did commit the crime. Suppose, then, that he is found to be an irresponsible lunatic, is he because of that fact less dangerous to the community? On the contrary, we ought to feel much safer with a responsible criminal at large than with an irresponsible one. Then why the necessity for a definition of responsibility for mere purposes of conviction. It has been suggested by White, I believe, that responsibility is something with which we endow the criminal, and not a something, a quality which actually resides within the criminal. One might go a step further and say that this imperative demand for the settling of the question of responsibility touches society much more vitally than it does the issue itself. A man is found to have committed a crime; society becomes aware that it has to do something to him; it wants to do the thing in a civilized and "just" manner; it wants to give him in the line of punishment all that he deserves but no more and no less; hence the necessity for establishing the precise degree of accountability.

But what has all this fiction to do with the real object of criminal justice, with the purpose of reclaiming the delinquent for the safeguarding of social order unless we admit what is historically the fact—that the criminal law is not concerned with this forward-looking aim, but is still largely, if not wholly, an instrument of retaliation. This conclusion is inescapable if we contemplate the fact that over two thirds of our prison population is made up of recidivists who have been handled repeatedly by the machinery of the law in the same unimaginative manner of so much punishment for so much crime, a method whose sole concern at best has been the satisfaction of the requirements of the statute, and under which no attention is paid to the concrete needs of the individual case. The aims and methods of the penal law will continue to be largely what they have been until the psychiatric issues in criminal behavior receive more emphasis than courts and lawyers are as yet ready to allow, and unfortunately, this opposition will be reinforced just so long as psychiatrists will continue to restrict their conception of mental medicine to the field of the clearly classifiable and perhaps committable psychotic entities.

Approximately one half of the inmates of Sing Sing Prison present psychiatric issues sufficiently clear to demand recognition if a proper understanding of the type of behavior that brought them into prison and that will condition their future careers is to be had. And if any attempt at intelligent treatment is to be undertaken, the other half, too, must be approached and studied from the psychiatric point of view. The imposition of a sentence to prison may well serve to satisfy the demands of the law, but if it is to have any constructive effect upon the future conduct of the individual so sentenced and not merely to beg the question of his ultimate fate, a clear understanding of his specific capacities, needs and disabilities must be gained.

Our first aim, therefore, in criminology, might well be the emphatic demonstration of the fundamental truth that if the criminal process is ever to become a really effective instrument of social control, it must look beyond the immediate criminal act and the statutory prescription for the solution of the problem created by it to the human being back of the act, and that it must employ principles of diagnosis and treatment which have been found to be indispensable wherever problems of maladjustment have been adequately handled. The time has arrived when the psychiatrist must take a definite stand with reference to the problems of criminal behavior, not merely as an aid to courts in clarifying issues of accountability but through an emphasis of the principle that problems of misbehavior cannot be properly defined by the statute book, and that constructive treatment is impossible without individualization in definition which the law book is incapable of providing. This at once suggests another very attractive aim. Such psychiatric work as has already been carried out in the field of criminology has provoked considerable interest and demand for enlightenment on the part of the public. Unfortunately we are too little prepared as yet to render dependable information for the guidance of court and institutional authorities. It should be, therefore, the aim of psychiatry in this field to undertake to furnish the fundamentals for a dependable science of criminology so that eventually a psychiatric study of a criminal case should be adequate to supply, at least, the following information:

1. A definition from the psychiatric standpoint of the type of problem presented in a given case.
2. A scientific analysis of the various causative factors operative in the given case.
3. An outline of the most promising plan of treatment for meeting at the same time the needs of social security and the individual prisoner's reclamation.

It would be regrettable if in his efforts to meet the above requirements, the psychiatrist were to fail to make full use of the lessons that the developmental history of psychiatry itself has taught him. Absolute safety unquestionably lies in adhering to the descriptive level in psychiatry, especially when one undertakes recommendations for radical changes in procedure. But the possibility of a much more intimate understanding, and in consequence a more natural, humane and constructive treatment lies in the analytic and interpretative approach. In the borderline zones of psychiatry it is much more important to get away as far as possible from concepts that are static and to be thoroughly alive to the constant and continuous interplay between the living forces within the individual and the equally vital influences of his environment.

Man is born with certain innate endowments, it is true, but the very process of life itself constantly modifies these endowments. The feebleminded individual is never the same individual after having served a sentence in prison, and economic conditions and manner of life do exert a potent influence on the process and progress of recovery from even so simple a disorder as nervousness. What might justly be regarded as the source of a mental difficulty today may lose much of its significance tomorrow. The same is true when we come to prognosticate. For instance, the lessons which the modern approach to psychiatry has taught us concerning the nature of the deterioration process in dementia praecox should be found particularly helpful in dealing with borderline issues. Just as deterioration in this disorder is now considered to have more of a functional, dynamic quality, so deterioration in social and economic fields does not necessarily involve a fixed structural modification but is amenable within wide limits to therapeusis.

As to the first requirement. The seriousness of the criminal problem lies in the large amount of recidivism, with the utter inadequacy of traditional disciplinary methods for bringing about desired changes in behavior in so large a proportion of our reformatory and prison population. There are many causes for this, but none more significant than the gross indifference on the part of those who administer the problem at its various stages to the fundamental issues involved in individualizing justice. When a prosecuting attorney offers a bargain to a seasoned crook, who has already experienced a number of previous convictions, on terms such that a tenth offender is given the privilege of pleading as a second offender, and is thus encouraged by the representative of the law to commit perjury for the mere object of expediting the conviction, the official is unwittingly degrading the business of justice to the level of a huckster's transaction. Nor has he any interest in the general problem of combating crime beyond the opportunity it affords him to accumulate personal political prestige by means of convictions. He sees in his own work a self-sufficient good, independent of any ultimate aims of the penal process. That the attitude of other agencies in the process is of a similar nature, sufficient proof exists. But experience seems to indicate that these misconceptions and perversions of the instrumentalities of criminal justice have their roots in a lack of understanding, rather than in corrupt intent, and this lack may in large measure be met by the application of the psychiatric technique to the development of scientific criminology.

The commission of a criminal act creates a problem which in most instances has far deeper implications than the mere cataloguing of the crime and the application of a just penalty would suggest. It involves questions of human behavior, of living forces which demand understanding before they can be properly directed.

The problem of the individual case may be a purely medical problem and as such the sole concern of the physician. The epileptic who in a dromomanic seizure is pursued by a suspicious policeman from whom he breaks away only to be stopped by a bullet from the officer's revolver will obviously not derive much benefit to say the least, from a sentence of two years in state prison for the alleged offense of assaulting an officer. Neither is it conducive to the safety of the public to release this man after the expiration of his sentence. His problem is strictly a medical one.

Or the problem might primarily be a sociologic one, demanding attention to some crime-provocative social situation. The policeman who arrested an ex-prisoner whom he believed had reformed, admitted to us that he could not make up his mind whether or not to arrest the man but finally concluded that, inasmuch as it was as unusual hour of the night for anyone to be out, he might as well run him in. Incidentally, it was the same police officer who had sent him to state prison on a former occasion. This man had lost two fingers while serving the last sentence and had fully determined never to expose himself to a similar experience again. A thorough investigation revealed the fact that the prisoner actually had been at work since his release from prison, that he was on a legitimate errand on the night of his arrest, but that his previous record and a threatening lecture by the judge intimidated him into confessing to an intent to commit the crime, and so he was returned to state prison to serve another four years.

It may be argued that such matters do not come strictly within the psychiatrist's sphere of interest. But if the psychiatrist is to keep in mind the readjustment of the individual and not solely the abstract satisfaction of the law, he must make experiences of this nature a matter of his interest. The mental attitude which an experience such as this creates in the prisoner is not conducive to reformation. The recent case of a man who on three occasions was saved from the electric chair by a hair's breadth, and who was eventually discharged into freedom because a reinvestigation of the case revealed that he had had nothing to do with the murder for which he came so very near being executed, demonstrates the serious menace inherent in the administration of justice purely from a desire to satisfy the latter and not on the basis of an impartial estimation of the facts in the case. The problem of the individual prisoner may be one purely for judicial administration as in the case of the bank wrecker or greedy speculator. I do not wish to be understood as being unqualifiedly opposed to the idea of punitive justice, I can well conceive of cases where punishment might have some value, but always only as a means to an end. It immediately ceases to be of value and, on the contrary, becomes a detriment if it is conceived to be an end in itself. No two prisoners present exactly the same problem, certainly not when one has in mind reconstructive requirements in the individual case. Should not psychiatry claim as peculiarly its own this important task of scientific definition of the problem of the individual delinquent?

The fulfillment of the second requirement, namely, the scientific analysis of the causative factors in the given case, would not only serve to emphasize the need for individualization in treatment, but would ultimately furnish a basis upon which a dependable science of criminology could be built. The subject of causation of crime is still immersed in great obscurity and yet it constitutes the prime essential for the ultimate development of a science of criminology. I cannot enter here into detailed discussion of diagnostic methods, except to sound a note of warning against the error of assuming a "cause and effect" relationship where only coincidences exist.

The establishment of a diagnosis of feeblemindedness or mental disorder in a given case may not and frequently does not explain the cause of the criminal act. The criminal act can only be viewed as a reaction on the part of a particularly constituted personality to a particular stimulus, internal or external as the case may be, and the proper understanding of it requires an analysis of all the factors in the case. There are many feebleminded individuals who are leading useful serene lives, and mental disorder need have nothing in common with criminal behavior. On the other hand "circumstances of life" play a tremendous rôle in the selection of those who get into prison. One of the most striking arguments ever brought forth against capital punishment was voiced by a learned lawyer of wide experience who objected to it because as far as he was able to ascertain the death penalty had never been paid by anyone who possessed both wealth and influence.

But the fact that there may be no strict relationship between an existing mental disorder or defect and the criminal act, and that many criminals present no strictly psychiatric issues, does not in the least render a psychiatric approach in all cases less desirable. All that a case may require may be the study of the "natural history of the crime." This in itself frequently brings to light a highly significant play of mental forces which although not sufficiently objective to constitute a psychiatric problem in the strict sense of the word cannot be ignored if the crime is to be properly understood. Many cases would have been much more rationally administered if a dependable natural history of the crime were had.

Were the fundamental determinants of behavior among offenders against the law of a radically different nature from those which the practicing physician meets every day among his patients, it might be necessary to enter into a detailed discussion of the therapeutic possibilities in this field. Unfortunately this phase has been cultivated very little. The mere fact of a recidivism has been taken as proof of irreformability. That such is not the case, ample proof exists. Over and above those offenders whose constitutional limitations restrict therapeutics to mere custodial care, or to endeavors to improve their economic proficiency, there are many delinquents in whom methods of approach similar to those employed in daily psychiatric practice might bring about excellent results. Many of them are immature in their emotional expressions; strikingly few know, for instance, of any play outlets other than those which inevitably expose them to conflicts with the law. A reconditioning of desires to bring these more into accord with their capabilities has worked well with some. Deficient training and a restricted one-sided life experience limits many of them to a very meager choice of alternatives of action when confronted with a difficult situation. What appears in some as an organically fixed tendency to misbehave proves to be amenable to treatment within wide limits. In some cases, significant emotional experiences in early life have a determining influence in shaping the criminal career. Neither are the anti-social grudges which some of them develop, justly or unjustly, necessarily permanently fixed. It is decidedly premature to dwell too much at this time upon results from individual psychiatric therapeusis. Such efforts, however, as have been put forth in this direction justify the opinion that the traditional attitude of hopelessness and futility is neither scientific nor correct and that final judgment in a given case cannot be rendered until after all available psychiatric efforts have been exhausted. The individual therapeutic approach to this problem constitutes perhaps the most attractive aim of psychiatry in this field.

The field of criminology is a wide one—as wide as that of psychiatry itself—and the problem of crime is one of the most serious and pressing with which society has to cope. A brief paper on the subject can at best be but a meager and inadequate sketch. I have merely undertaken to invite your attention to some of the more outstanding points that might be of help for orientation concerning psychiatry's place in this field. Those of us who work within the borderline zone of psychiatry and come in close contact with the truly vital issues within it, view with a mixture of respect, admiration and some timidity the growing aggressiveness of the intelligent, capable, social worker who demands information and who has come to look for it in the field of mental medicine. The challenge is an attractive one. As psychiatrists, are we prepared to meet it?

THE FIRST TEN YEARS OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, WITH SOME COMMENTS ON ITS FUTURE*

LEWELLYS F. BARKER, M.D.
President, The National Committee for Mental Hygiene

As this is the tenth annual meeting of The National Committee for Mental Hygiene it would seem a suitable time for retrospect and prospect. The past decade has been for us, as you know, a period of originating, of planning, of organizing, of surveying and of financing. Much has already been accomplished and still more is under way. When we recall that only a decade has elapsed since Mr. Clifford W. Beers published his autobiography, *A Mind That Found Itself*, and, through its timely use, secured the consent of a group of influential men and women in this country to cooperate as a committee, we must be impressed by the quantity and the variety of work that has been done and by the amount of interest in mental hygiene that the activities of the Committee have aroused. The success of this movement toward the betterment of mental hygiene in the United States has been due in part to its timeliness, in part to the prestige of its sponsorship, in part to the generosity of Mr. Henry Phipps, Mrs. Elizabeth Milbank Anderson, Mrs. William K. Vanderbilt, Mrs. E. H. Harriman, Mrs. Willard Straight and, more recently and, on a still larger scale, of the Rockefeller Foundation, in supplying necessary funds, and in part to the energy and devotion of its officers, among whom I may mention its first president, the late Dr. Henry B. Favill; its vice-presidents, Dr. Charles W. Eliot and Dr. William H. Welch; the chairmen of its executive committee, successively Dr. Adolf Meyer, Dr. George Blumer, Dr. August Hoch and Dr. William L. Russell; the chairman of the finance committee, Prof. Russell H. Chittenden; the chairman of the committee on mental deficiency, Dr. Walter E. Fernald; the chairmen of the war work committee, Dr. Pearce Bailey and Dr. Charles L. Dana; the treasurer, Mr. Otto T. Bannard; the secretary, Mr. Clifford W. Beers; the associate medical director, Dr.

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* President's address at the tenth annual meeting of The National Committee for Mental Hygiene held in New York City, February, 1918.

Frankwood E. Williams, and, above all, the medical director, Dr. Thomas W. Salmon.*

Some years ago I defined the campaign for mental hygiene as "a continuous effort directed toward conserving and improving the minds of the people. . . . a systematic attempt to secure human brains so naturally endowed and so nurtured that people will feel better, think better and act better than they do now." Emphasis has always been laid upon the relations of heredity on the one hand, and of environment on the other, to the way in which people feel and think and act. Among our objects we have laid stress on "(1) the protection of the mental health of the general public; (2) the promotion of the study of mental disorders and mental defects in all their forms and relations, and the dissemination of knowledge concerning their causes, treatment and prevention; and (3) the amelioration of conditions among those already suffering from mental disease or mental deficiency." Our three main fields of work have been original inquiry as to the problems of mental hygiene, the education of the nation to use the knowledge that scientists have already accumulated, and the organization of agencies for the carrying on of the campaign.

ORIGINAL INQUIRY

Briefly to summarize the activities of the Committee in original inquiry, I may say that they have included:

1. The preparation of a summary of the laws regarding the care and commitment of the insane in the several states, published in 1912; revised edition, 1917.

2. The preparation of an accurate directory of all existing institutions in the United States for the care and treatment of the insane, feebleminded, epileptic and inebriate, and census studies of these institutions.

3. The collection and filing of detailed information regarding these special institutions, State Boards in authority over them, personnel of Boards, methods of appointment, degree of responsibility, methods of work and efficiency.

4. The accumulation of data regarding psychiatric clinics, the teaching of psychiatry, and the improvement of facilities for the early recognition, the treatment, and the prevention of mental disease and of mental deficiency.

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* Since this address was delivered Dr. Walter B. James has been elected a vice-president and also chairman of the finance committee.

5. The establishment of a central library at the office of the Committee, in which books and pamphlets bearing upon mental hygiene, psychiatry, neurology, psychology and allied subjects are being assembled and catalogued. This card catalogue will eventually serve as an index to all books and articles on these subjects in all languages.

6. The undertaking of surveys, state by state, of the condition of the insane, their public care and treatment. These surveys have been made by competent psychiatrists, selected and supervised by the National Committee. Every effort has been made to secure accurate, impartial and scientific reports of the conditions that actually obtain in the several states surveyed in order that a sound basis for betterment may be provided. Surveys have already been made in Pennsylvania, South Carolina, Texas, Tennessee, Connecticut, California, Louisiana, Georgia, New York City, Colorado, Cook County, Illinois, and Indiana, and other surveys are planned. The cost of these surveys (some $35,800) has been defrayed by an appropriation made by the Rockefeller Foundation, and an excellent account of the results achieved by these and other special activities of the National Committee will be found in the report recently made to the Rockefeller Foundation by its secretary, Mr. Edwin R. Embree, the substance of which will soon be issued in pamphlet form by the National Committee.

7. The making of surveys of the public care and treatment of the feebleminded and the advising of State Commissions on Provision for the Feebleminded. An appropriation of $39,250 was made by the Rockefeller Foundation for work of this kind undertaken by the National Committee in 1917 and 1918. In 1917 such work was carried on in Kentucky and in Maine by psychiatrists with special knowledge of the problem, and a similar survey is soon to be begun in Mississippi. Through such surveys much will be done to detect feeblemindedness that would otherwise escape recognition; to lead people in the community to provide the best kind of continuous institutional care for the feebleminded and to see to it that they are given such care; to provide for suitable education for the feebleminded and through intelligent supervision to protect the community from the injurious effect of feebleminded persons who do not receive continuous institutional care.

8. The demonstration of the value of a scientific intensive study of the prevalence and significance of mental abnormalities (disease

or deficiency) in a single community and the setting of standards for such a study. In 1916 an intensive study of this sort was made of Nassau County, New York, by a staff of six physicians and seven social workers, supervised by an advisory board of The National Committee for Mental Hygiene and its medical director. The cost ($10,000) was met by an appropriation from the Rockefeller Foundation.

9. The demonstration of the value of studies in the psychopathology of crime. For this purpose the Rockefeller Foundation appropriated to our Committee some $47,500. During 1916–1918, studies of the causes underlying crime were pursued at a psychiatric clinic in Sing Sing Prison by Dr. Bernard Glueck, under our supervision. During 1917–1918 psychiatric and social studies have been conducted under this appropriation by a staff of skilled workers at the Children's Court in New York City; these studies have not been confined to the children themselves but have included careful inquiries into the conditions of their homes, their families and their environment.

10. The establishment of a Bureau of Statistics in our office (under a special appropriation from the Rockefeller Foundation) which is forwarding, in connection with the Committee on Statistics of the American Medico-Psychological Association, a movement toward the establishment of uniform statistics concerning mental diseases and the securing of their adoption throughout the whole of the United States.

11. The assistance given to the United States Government in its war work, (a) in eliminating from military service those who are unfit mentally or nervously, (b) in planning for the care and treatment of those members of the United States forces who, during the war, develop signs or symptoms of nervous or mental diseases and (c) in arranging for the reconstruction, so that they may return either to the Army or to civil life, of those men in service who become disabled nervously or mentally. In 1917 our medical director, Dr. Salmon, was sent to Europe to make a special study of war neuroses (so-called "shell shock") and other nervous and mental disorders in the British Army. His report has been of great service in formulating plans for work on the same problems in our army. As you know, Dr. Salmon (now a Lieut. Colonel in the Medical Corps, N. A.) has been granted leave of absence to serve as Senior Consultant in Psychiatry with

the American Expeditionary Forces in France. It is a source of real satisfaction to know that this neuropsychiatric work will be so competently directed. The Surgeon General of the Army has accepted as a working program plans drawn up by our Committee including:

(a) The establishment of a Division of Neurology and Psychiatry in the Medical Corps of the United States Army, with Dr. Pearce Bailey in charge, with several hundred psychiatrists, neurologists and psychologists in service, and with special courses of instruction in military neuropsychiatry for officers in the Medical Reserve Corps. A psychological section, with Prof. Robert M. Yerkes at the head, was later created in the office of the Surgeon General.*

(b) The "weeding out" of those who are unfit nervously or mentally to do army work, of whom several thousand have already been excluded.

(c) The organization, equipment and manning of special neuropsychiatric wards in the military hospitals in the cantonments and in the field.

(d) The preparation for the work of reconstruction of those becoming nervously or mentally disabled in service.

What has already been accomplished by our War Work Committee will be detailed by the Associate Medical Director, Dr. Frankwood E. Williams,† in the report he is to make today. For the organization and conduct of the part of this war program that has been carried out by the National Committee, the funds have been supplied by Miss Anne Thomson of Philadelphia who contributed $15,000 at the beginning of the work, and by the Rockefeller Foundation, which appropriated $25,000 for this purpose in 1917 and 1918, in addition to defraying the expenses of Dr. Salmon's studies while abroad.

In the field of original inquiry, then, we may feel that very satisfactory progress has been made. The problems already under attack are large and important. Much energy, great enthusiasm and large sums of money will be required to solve them.

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* Since this address was made, two Divisions have been created with the approval of the Surgeon General, namely, the Division of Neurology and Psychiatry with Colonel Pearce Bailey as Chief, and the Division of Psychology with Major Robert M. Yerkes as Chief.

† On June 1, 1918, Dr. Williams was granted leave of absence by the National Committee, to enter the Army. He is now a Major in the Medical Corps, on duty in the office of the Surgeon General at Washington.

EDUCATION OF THE PUBLIC

One of the three primary aims of the National Committee is to educate the public regarding the conditions of inheritance and of environment that underlie healthy feeling, thought and action on the one hand, and abnormal affectivity, ideation and behavior on the other. The ignorance that exists regarding the facts that have already been accumulated dealing with these subjects, even among presumably well-educated people, is amazing and deplorable. It is, doubtless, this ignorance that accounts for much of the apathy and prejudice that workers in the field of mental hygiene find to prevail. Discouraging as the situation would seem to be at first sight, the manner in which the wider public is responding to the judicious appeals and to the educative efforts of those working under the auspices of the National Committee gives good grounds for the hope and expectation that the campaign of education begun will rapidly grow and prove to be fruitful in results.

Among the efforts at popular education already made by the National Committee may be mentioned:

(1) The publication and distribution of pamphlets and reports dealing with the subject of mental hygiene and with the work of the National Committee.

(2) The distribution of many copies of *A Mind That Found Itself*,* in which an account of the origin of the National Committee and the growth of its work are presented.

(3) The regular publication since January 1917 of an official organ, a quarterly magazine entitled MENTAL HYGIENE, in which "non-technical articles on the practical management of mental problems in all relations of life" appear, articles that should interest "all thoughtful readers, especially physicians, lawyers, clergymen, educators, public officials, and students of social problems."

(4) The utilization of a mental hygiene exhibit (as suggested by Dr. Stewart Paton) for the education of the public. When the exhibit has been shown in a city or town, public meetings have been arranged for in connection with it, suitable speakers secured, and newspaper and magazine publicity made use of, with the result that widespread interest in mental hygiene has been aroused. A good idea of this part of the program can be obtained

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*An autobiography by Clifford W. Beers, fourth edition, revised, published in 1917 by Longmans, Green and Company, 443 Fourth Avenue, New York City.

by a perusal of the illustrated *Handbook of the Mental Hygiene Movement and Exhibit*, issued by the National Committee.

(5) The answering of inquiries regarding all sorts of mental problems, personal and public, many of them necessitating a considerable amount of investigation, including consultations with experts in special domains. Some of the officers of the National Committee have given much of their time and energy to this kind of work since they have felt that the Committee should try "to serve as a clearing house for the nation on the subject of nervous and mental disorders and mental deficiency, and the care and treatment of the insane and the feebleminded."

(6) The making of appeals at different times to committees in Congress and to officers of the United States Government (including the President) regarding the importance of mental hygiene in its relation to preventive medicine, to immigration, to insular and territorial affairs, to the care of the Indians, etc. One significant advance likely soon to be made, which the National Committee is furthering, is the establishment of a Division of Mental Hygiene in the United States Public Health Service.

ORGANIZATION OF AGENCIES

Turning now to the agencies that have been organized for carrying on work in mental hygiene, we find a gratifying record. Without entering into details, the larger undertakings may be mentioned. They include:

1. The organization, in 1909, of the National Committee itself by Mr. Clifford W. Beers, the Secretary of the Committee; and its incorporation, in 1916, under the laws of the State of New York; the division of its work among a board of directors, an executive committee, a finance committee, a committee on mental deficiency, a war work committee, several special sub-committees and an executive staff at the headquarters in New York City. Much of the success of the work has depended upon the intellect, energy and enthusiasm of the Medical Director, Dr. Thomas W. Salmon, whose services we were fortunate to enlist in 1912 when our active work began.

2. The organization of state societies for mental hygiene for the purpose of prosecuting intensively a mental hygiene campaign within the confines of each state. Eighteen state agencies for mental hygiene have already been established, in the organization of all but three of which the Secretary of the National Com-

mittee has been directly instrumental. In the order of their establishment such societies have been organized in Connecticut, Illinois, New York, Massachusetts, Maryland, Pennsylvania, North Carolina, the District of Columbia, Alabama, Louisiana, California, Rhode Island, Ohio, Tennessee, Missouri, Indiana, Iowa and Virginia. A state society for every state in the Union is an ideal toward which we are working and which will certainly be attained for the interest in such agencies has now become country-wide.

3. The holding of conventions of societies for mental hygiene, under the auspices of the National Committee. In 1914, the first convention of this kind was held in Baltimore, and in 1916 there was a second assembly in New Orleans.

4. The extension of aid to other countries in organizing committees for mental hygiene. It may be permissible to mention that a project for the formation of a Canadian National Committee for Mental Hygiene is taking shape, and that the Secretary of our Committee has been invited to go to Canada this month to participate in the work of organization.*

Furthermore, when Dr. Salmon was in England during the past year, he was asked by Sir William Osler of Oxford to address a group of medical men there upon the origin and work of our National Committee, and it seems likely that, in due time, an English National Committee for Mental Hygiene may be established. It is conceivable that other nations will also establish national committees for mental hygiene as the need for them is universal.

Our committee was very wise in beginning its practical work slowly, in thinking a great deal and planning before trying to do much. We were perhaps forced to a slow development in the beginning because of the difficulty of securing funds for so new a work, but it may not have been bad for us that we were compelled to devote a large amount of time and energy in the early years to the formulation of plans, and that we were not able rapidly to put them into effect. When we compare the work already done, however, with the program that was outlined some years ago, one involving original inquiry, popular education and organization of agencies, I think we have a record that is encouraging to us and that will be a stimulus to those who will engage in similar undertakings in other countries.

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*Since this address was made, the Canadian National Committee for Mental Hygiene has been fully organized, leading men and women in the Dominion having been interested in the movement. Its office is at 143 College Street, Toronto, and its Executive Officers are Dr. C. K. Clarke, Medical Director, and Dr. C. M. Hincks, Associate Medical Director and Secretary.

SUGGESTIONS FOR THE FUTURE

Pleased as everyone must be with our retrospect, you will want me, I know, to say something also of prospect. The end of a decade would seem to be an especially suitable time to look carefully at our situation and to plan intelligently for further work. Intensely interested as we are in the fruitful activities already entered upon, we must remember that these activities pertain to a field that is small and strictly circumscribed in comparison with the larger area that must, in the long run, be cultivated if we are to perform, in any sense of completeness, the functions that the name of our Committee connotes. What we have been doing thus far has been to try to invent methods for applying the science of psychiatry to the problems of mental hygiene and to some small extent to apply these inventions to mental hygiene as an art. Ought we not at this time to take a more comprehensive view of our possible functions as a national committee for mental hygiene and to ask ourselves what we may profitably do to enlarge our activities so that they may be more in accord with the possibilities that are perceptible? That such a view and such a question will be welcomed, I feel certain, and with your permission I shall devote the rest of my remarks on this occasion to them.

What we have undertaken thus far has, I believe, been scientifically well founded. Anything we undertake in the future should also be so founded. Let us recall for a moment the difference between activities that are not, and those that are, based upon science.* In the one instance action tries to satisfy desire in a direct way. It tries to go straight to its object without any knowledge of intervening obstacles or consideration of the ways of evading them. It is ignorant of laws and principles. It is not intelligently directed, but is a kind of "muddling through," and is enormously wasteful of energy. In the other instance, action tries to satisfy desire, but in a more indirect way. There is a realization that the longest way around is often the shortest way home. Facts are collected and arranged; the laws underlying them are discovered, that is to say, the order in which events occur is found out. The various principles that have to do with the means or instruments by which effects are produced are established and the ways in which these principles may be utilized are thought out. Then the best route towards the satisfaction of the desire is followed. This method is intensely economical with energy. A *pure science* arises through observing facts, arranging them, forming hypotheses concerning them, reasoning out the bearings or implications of the hypotheses, comparing these implications with the facts observed, making further observations or experiments, when necessary, for testing the hypotheses or inferences as reasoned out, and, finally, arriving at conclusions or beliefs regarding the order of events (or the uniformity of sequences). It consists of a search for "truth for its own sake." An *applied science* arises through the perception of possibilities of utilizing the conclusions arrived at by a pure science, and through the making of such adjustments as are necessary in order that the phenomena can be so modified as to serve man in his efforts to satisfy his desires. In other words, an applied science finds out how to utilize truth to help man to secure what he wants. It consists largely of what we call "invention." The practice of an *art* may be defined to be the actual skillful use of the inventions of an applied science (based upon the laws and principles of a pure science) in producing results desired by man. My thesis today is to maintain that our National Committee should do everything possible to favor the development of (1) a pure science of mental hygiene, (2) an applied science of mental hygiene, and (3) an art of mental hygiene.

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*Gore, G. Art of scientific discovery. Lond.: Longmans, 1878. Jevons, W. S. Principles of science. N. Y.: Macmillan, 1913. Pearson, K. Grammar of science. Lond.: Black, 1900. Strong, T. B. Lectures on the methods of science. Oxf.: Frowde, 1906. Thomson, J. A. Introduction to science. N. Y.: Holt, 1911.

All will agree that the field of mental hygiene, like every other domain in which natural forces are at work, is one in which facts may be collected, arranged and reasoned about, and one in which laws that are capable of practical application can be discovered. Chance plays no greater rôle in our province than it does in any other. Laws will be found to govern in it; principles can be established that will hold in it; practical methods of applying these principles can be devised in it; and these inventions can be put to use in it to secure the results we desire. In mental hygiene as in every other subject, we must know in order to predict and to gain the power to control.

Now a pure science grows but slowly and practice begins in a crude empirical way long before an art in the true sense (based upon science) can be developed. This has been true of medicine as a whole. Human beings have at all times been confronted with other human beings who were sick or suffering and whom they wished to help. They tried to help, but first in only a very blind way. The primitive healer had to do the best he could before there was any science of medicine. In acting, however, he gradually acquired a certain experience. Through the ages, the phenomena of disease have been observed and gradually an enormous number of facts have been accumulated and classified. Through experimentation, observation has been made more precise. Slowly the laws to which phenomena conform have begun to be recognized until medicine has become a science, though, it must still be admitted, only a partially developed science. The knowledge already gained and the truths already discovered have permitted the making of many useful practical applications by inventive physicians, and these are now daily employed by those who practise the art. The art of medicine in our time is much more advanced and requires very much more skill than, for instance, in the time of Hippocrates. As it has been with medicine as a whole, so we may expect it to have been, and to be, with mental hygiene. Men's feelings have been aroused by observing the insane, the idiotic, the imbecile, the criminal, the alcoholic, the drug habitué, the hypochondriac, the timid, the asthenic, and the ineffective. We desire to see more individual happiness and better social adjustments. We want all people (including, of course, ourselves) "to feel better, to think better and to act better than they do now." Our feelings and our desires are driving us to act, but we are far from knowing, as yet, how best to act. We must in mental hygiene, as in anything else, appeal to intellect as the directive agent to aid us in satisfying our desires. We must use our heads in order that our hearts shall not drive us blindly. We must develop a pure science of mental hygiene, discovering the laws that govern the phenomena that interest us; we must cultivate an applied science of mental hygiene, devising practical applications of these laws; for only thus can we be provided with the inventions that will permit of a satisfactory practice of an art of mental hygiene.

If, now, we ask ourselves, How can we, by taking thought, contribute in an orderly way to the development of mental hygiene in the larger sense referred to, it will be obvious, I think, that our first task will be to consider the position that a science of mental hygiene would necessarily occupy in systematic classifications of all the sciences, to inquire into the relations of our science to other cognate sciences, and to decide upon the kinds of facts that must be gathered and investigated to serve as data to be reasoned about in creating this special science. In other words, this first task will consist in establishing what might be called a "philosophy of mental hygiene," for the philosophy of a subject as distinguished from its science has been defined to be "the view or theory of the relations of the subject to other subjects and to the known world in general, as distinguished from the view or theory of it as isolated, or in itself." Our second task would be to consider in how far a science of mental hygiene has already been established and the direction that our work must take in order to develop this science further. The facts, or phenomena, available in the domain of mental hygiene must be arranged according to their similarities and sequences and a search made for uniform relationships, in other words, for the laws to which the facts conform. For until the data connected with mental health have been collected, arranged, and so systematized that they may be brought under general laws, a real science of mental hygiene cannot be said to exist. In all subjects of great complexity, attempts to ascertain causes and to show how effects are produced are peculiarly difficult. But faith in the great doctrine of causality moves mountains. We shall progress in mental hygiene only by acting on the belief that in it, as in all other domains we have to deal with phenomena that occur in regular order as the effects of natural or efficient causes, and that a sufficient knowledge of causal relationships makes possible the accurate prediction of effects. The natural forces that are at work must become known. The order in which events occur must be established. We must look forward to the time when the laws of energy that hold in complex domains are as well understood as the laws of gravitation and radiation now are in physics. That time is, of course, far in the distant future, but by looking and working toward it, in other words, by using the method of science, we shall make progress faster than is possible in any other way. For a philosophy of mental hygiene will delimit the boundaries of our science, will exclude from it what does not belong to it, and will make clear its relationships to all other sciences; and a science of mental hygiene will tell us just what mental hygiene is, will classify the facts that belong to it, will establish uniformities among these facts, and will show us how the truths thus arrived at can be applied in a practical way to increase human happiness by improving the feeling, the knowing and the striving of men.

Of the various attempts made to classify the sciences, none is better perhaps than that of Comte who divided all phenomena into five great groups, arranged in a series, depending upon the degree to which the phenomena can be precisely determined, in other words, depending upon their relative complexity. This series includes (1) astronomy, (2) physics, (3) chemistry, (4) biology and (5) sociology. It would probably be better, as Spencer and Ward have suggested, to include one new member, namely psychology, in the series, and if this is done, psychology will obviously occupy the fifth place, standing, as regards complexity, between biology and sociology. All other sciences can be satisfactorily assigned to natural positions under these several great coordinate sciences. For these six sciences represent an arrangement that is serial and genetic, and each of them stands at the head of a hierarchy of sciences in which a synoptical or logical classification of subordinate sciences is more or less feasible, the more general sciences forming genera with each genus including its appropriate species. Medical science is one such branch and among the special medical sciences we may include mental hygiene.

In studying the relationships of mental hygiene to other sciences we do two things; first, we see just how mental hygiene differs from these other sciences and so contribute to a philosophy of mental hygiene; and, secondly, we gather from the other sciences facts from which inferences that are important for mental hygiene itself can be drawn, thus securing data that will serve as a basis for a science of mental hygiene. The relationships of mental hygiene might be illustrated by reference to any of the sciences, but let us choose, as examples, biology, psychology, sociology, ethics, and politics, with their subordinate sciences. Obviously, mental hygiene is very closely related to these great sciences. Indeed, the science of mental hygiene must be built up largely upon a foundation of data derivable from these sciences.

Thus *biology** has to do with the phenomena of life and with the evolution of living organisms of ever-increasing complexity and efficiency, the highest type of which yet produced is man. Life on this planet at some time or another had a beginning, perhaps fifty or one hundred million years ago. Living things only very gradually increased in complexity, and in efficiency, through the millions of years that correspond to the several geologic periods. Archeologists and ethnologists estimate that the human period dates back only about 25,000 years, though Pithecanthropus, or some sub-human ancestor of man, is believed to have been widely distributed in late Tertiary or early Pleistocene times (300,000 years ago). Biologists, as everyone knows, try to account for the mutability of species and the genealogical descent of organic forms. They study "the struggle for existence" and arrive at the "principle of natural selection" under the "law of advantage." The biological sciences of zoology and botany describe and classify all animal and vegetable forms. Anthropology considers a single member of the animal kingdom, man. Anatomy deals with the structure, physiology with the functions, of all the forms. Cytology has to do with the biological unit, the cell and its construction, and the physical basis of heredity. Embryology deals with the early development of the individual form and makes the surprising discovery that the history of the development of the form of a race is repeated in an abbreviated way in that of the individual. Living things are sentient and there is biological evidence that in the animal kingdom there are observable signs of an ascending scale of sentiency from the feeblest awareness of the lowest forms to the most complex psychic phenomena of the highest animals and men. Through an evolutionary process, organisms influenced by environment have gradually acquired psychic powers (proportionate in the higher stages to the development of their nervous systems) that have been increasingly advantageous to them. The struggle for existence has not only not been incompatible with, but seems to have been responsible for, the appearance and growth of mind. Surely, any science of mental hygiene will have to consider the biological factors that account for the origin of mind, its growth, and the modifications it has undergone.

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*Hobhouse, L. T. Mind in evolution. Lond.: Macmillan, 1915. Spencer, H. Principles of biology. N. Y.: Appleton, 1893. Thomson, J. A., and Geddes, P. Evolution. N. Y.: Holt, 1911. Thomson, J. A. Science of life. Lond.: Blackie, 1899.

But biology also teaches that evolution is not always upward; it is not always what has been called orthogenic, or aristogenic, evolution. The latter seems to have depended upon, or at any rate has been associated with, the growth of mind. Since biological study may help to explain evolution downward (e.g., parasitism), and may throw light upon conditions that lead to mental retrogression, it is clear that, in this field also, its results may be of importance in the construction of a science of mental hygiene.

In the study of the adaptation of human and animal behavior to the demands of life and growth, the biologist becomes familiar with various forms of correlation between the experiences and actions of the individual and of the race. In the lowest stages, the method of correlation is based on the principle of heredity; development is blind and apparently what we call mechanical. In the later stages, the methods of correlation are less rigidly defined by physical heredity; for in them the experience of the race becomes influential in other ways, for example, through tradition and history; and development is less "mechanical," ultimately tending to become consciously "purposeful" and "self-determining." The living organism learns to know that to which it may attain, sees how it may master the conditions of its advance and moves in an orderly manner towards the goal it perceives. Instead of being the mere mechanical resultant of inheritance modified by environment, the organism, through a rational system of correlation, consciously participates in determining the qualities that are to be inherited by its successors and systematically transforms the environment more fully to satisfy its desires and more closely to bring it into accord with ideals that it creates. Certainly all these factors that are concerned with animal and human organization and with the correlations that tend to bring life to the perfection of its development—factors that are the special province of biological study—dare not be ignored by the student who desires to contribute to a science of mental hygiene.

That the science of *psychology** must stand in the closest relationship to a science of mental hygiene goes without saying. Since the latter science has to do with the laws of health of mind, one prerequisite to its study will obviously be an acquaintance with the phenomena of mind, with the methods of observing them and with the results to which scientific men have attained by reasoning about them. The facts that are studied and observed by the psychologist, those upon which the science of psychology as at present understood is based, include (1) those of his own consciousness, and (2) those that can be summed up as the "behavior" of men and of animals as they strive for their own welfare and to secure their own ends, or achieve their own purposes, overcoming obstacles that may be in the way and making such adjustments as a varying environment necessitates. In observing carefully the stream of his own consciousness, the psychologist finds that during mental activity he is conscious, simultaneously or successively, of a knowing, of a feeling, and of a striving, and he describes these three aspects of his consciousness in corresponding technical terms—the "cognitive," the "affective" and the "conative." By becoming acquainted with cognition, affection and conation in himself as he lives, he learns to formulate the "relations of concomitance between modes of behavior and modes of consciousness" in others. He then goes further and seeks to explain both what goes on in consciousness and what is observable as associated behavior as a reaction of the living organism to the particular circumstances in which it is placed, and he finds that the kind of reaction that occurs in a given instance depends upon a certain organized set of conditions within the organism that he speaks of as the "constitution or structure of its mind." He is compelled to recognize that this constitution or structure is something that develops gradually in each organism and he infers that the way it develops is determined partly by inherent trends fixed by the ancestry of the organism (heredity), and partly by influences acting upon the organism from the outside (environment) that favor or inhibit the realization during life of the many inherited possibilities. He assumes that, on action, the knowing, feeling and striving faculties of the mind contribute certain enduring potentialities to the structure of the mind that make it able later to exercise these faculties upon specific objects or relations. Such enduring potentialities are known as "mental dispositions," and the mind as it grows becomes an ever-increasing complex of such mental dispositions that are functionally connected with one another to form a vast and elaborately organized system. The psychologist considers the manner in which such a system and its dispositions develop in the mind and discovers the laws of apperceptive discrimination, of apperceptive synthesis, of association, of reproductive imagination, of attention and of purposive selection and accentuation. What is ordinarily called "knowledge" is the structure of the mind in so far as it is cognitive (or knowing), and what is ordinarily called

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* James, W. The principles of psychology. 2 v. N. Y.: Holt, 1890. McDougall, W. Psychology; the study of behaviour. N. Y.: Holt, 1912. Morgan, C. L. Animal behaviour. Lond.: Arnold, 1900. Ross, E. A. Social psychology. N. Y.: Macmillan, 1908.

"character" is the structure of the mind in so far as it is affective (or feeling) and conative (or striving). Cross-connections between cognitive dispositions and conative dispositions also develop and become enduring features of mental structure. Good examples of such cognitive-conative associations are to be met with in the growth of sentiments such as the hatred of an enemy, the love of a friend, the love of one's country, the devotion to one's profession, or the dedication of one's energies to a humanitarian cause.

In the special branches of psychology, the study of mental dispositions and their linkage and organization into systems is limited to certain provinces. Thus one branch deals with these dispositions and systems in the normal adult human being, another with these in animals, another with these in children, another with these in persons who from their behavior indicate that they have abnormal or diseased states of mind, another with these of the "collective-mind" of society. Each of the special branches contributes its quota to the general science of psychology and helps in the discovery of the laws of structure, function and genesis of human mind. Just as studies of anatomy, physiology, and pathology are essential prerequisites for the science and art of medicine as a whole, so studies in the different branches of psychology are essential as prerequisites for the study of the science and the exercise of an art of mental hygiene.

Turning now to *sociology*,* a glance at the data of this science and the truths that have been discovered regarding the structure, the functions and the genesis of society will convince anyone, I think, of the importance of a consideration of the relationships of sociology to mental hygiene for all who are interested in the work of our National Committee. The sociologist, as Mill pointed out, inquires into the conditions of human nature that induce man to enter into a state of society; into the results that social relations determine in modifying his feelings, his interests, his desires and his conduct; into the influences that tend to ever closer association and cooperation for ever-multiplying purposes; into these purposes themselves and the machinery invented for serving them; into the many social structures that develop as the result of associative activity and into their functions; into the differences in these structures and functions in different states of society; and into the effects of each of these upon the intellect, the character, and the conduct of man. Sociology is a most complex science, for its generalizations are made from data collected by a whole series of special social sciences (ethnography, ethnology, technology, archeology, demography, history, economics, jurisprudence, politics, ethics). The social forces are described as consisting of the feelings and desires of the social units. These impelling motives include all the appetites (gustatory, sexual) that are concerned with individual preservation and with race continuance, and in addition all the desires (aesthetic, moral, intellectual) that have to do with race elevation. The social forces are, accordingly, psychic phenomena; they belong to the affective and conative systems of the mind and are to be looked upon as the dynamic agent that produces movement and change in the social domain, whereas intellect (or the cognitive system of the mind) is to be looked upon as the directive agent that guides the dynamic agent into safe and effective courses of behavior. As social forces continue to conflict and collide, states of comparative equilibrium result and social structures like the family, the clan, the tribe, the state, and the church, arise along with social institutions like language, marriage, government, customs, ethical and conventional codes, religion, art, literature, and science. The sociologist studies the functions of all these structures and institutions and observes how they are gradually modified and transformed into different and more efficient structures, explaining, as best he can, exactly how the changes take place. He is impressed with the view that it is effort to remove obstacles in the way of the satisfaction of desires that slowly produces the changes in social structures and institutions and is the cause of all social progress. This progress through which the social environment becomes transformed seems to depend partly upon simple evolution in the biological sense (in which the affective-conative systems of the mind supply blind motives undirected by the cognitive systems or the intellect), and partly upon a development in which the intellect (at first the individual and later the collective) foresees ends and the means to ends, makes these means desirable, and so consciously directs the social forces toward the ends through the way-station of the desired means. Lester Ward has called the simple evolution of society "social genesis"; to the development of society due to utilization of the social forces by the individual intellect, he has given the name "individual telesis," and to the development depending upon "the collective action of society in the direction of restraining, controlling, directing and utilizing in any manner the natural forces of society" he has applied the term "collective telesis." The sociologist looks upon the desires, passions and propensities of man as natural forces that can be directed in the service of society just as the physicist looks upon heat and electricity as forces that can be directed in the service of man. It is the function of the scientific investigator to discover the laws to which natural forces conform; it is the function of the inventor to perceive how these forces can be made useful and to contrive appropriate apparatus for their use; it is the function of the practitioner of an art to make use of the apparatus devised by the inventor, thus putting into execution the laws discovered by the scientist. The feelings, the emotions, and the desires of men must be understood and be consciously directed into useful channels in order that society may profit by them. Sociologists and psychologists have the task of using the intellect to discover the laws to which human desires conform, and statesmen have the task of using the intellect to invent means of inducing men to act for the good of society, of "making it advantageous to the individual to do that which is socially beneficial." To secure social reforms, this is the method that must be followed. In attempting reforms, the intellect will often make mistakes. Many unwise experiments, as well as wise experiments, will doubtless be made. The method of trial and error is unavoidable. The world today is witnessing a gigantic conflict between two great systems of government, each of which contains much that is "good" and much that is "evil." As a result of the collision, a system will emerge, we can be confident, that will have more of the good and less of the evil constituents than either of the entering opponents. It is this confidence and this hope alone that can reconcile us to the wholesale sacrifice that the peoples of the world are, at this tragic time, called upon and forced to endure. If sociology is the science that deals with social forces, social structures and institutions, social functions, and social progress (genetic and telic), the mere statement of the fact is surely sufficient evidence of the importance of this science to the student and practitioner of mental hygiene; for the mental hygienist, as much as anyone, desires to further that form of social progress that depends upon the power of the mind that makes man able to pursue ends that it foresees and believes to be advantageous.

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* Giddings, F. H. Elements of sociology. N. Y.: Macmillan, 1916. Small, A. W., and Vincent, G. E. Introduction to the study of society. N. Y.: Amer. Book Co., 1894. Small, A. W. General sociology. Chic.: Univ. of Chicago Press, 1905. Ward, L. F. Outlines of sociology. N. Y.: Macmillan, 1898. Ward, L. F. Psychic factors of civilization. 2 ed. Bost.: Ginn, 1906.

The relations of the science of *ethics** to mental hygiene are especially close, for ethics deals with reflective morality. It has to do with the behavior of men in moral situations, that is to say in situations in which considerations of "right" and "wrong" are involved. In trying to determine what behavior is right and what is wrong in a given situation in which action of one sort will result in consequences that are incompatible with those of action of another sort, men learn to be guided by their ideas of value or worth, selecting the activities that lead to the more valuable or worthy ends and rejecting those that lead to ends that are less valuable or worthy. Men who aim to behave ethically have to learn to distinguish the good from the bad in the situations in which they find themselves; they should become acquainted with the methods and principles by which ethical conclusions are reached, and should recognize the relations that exist between their own private satisfactions and the welfare of the social groups to which they belong. Hence ethical theory deals with problems of the "Good," its recognition, its mode of acquiring authority, and its relation to self on the one hand and to society on the other. In some types of ethical theory, emphasis is laid upon "good will," that is upon the spirit and motive of conduct; in other types of theory, the stress is placed rather upon the effects and consequences of behavior. Ethical theorists of today, however, endeavor to arrive at a correct understanding of "the mutual relations of attitude and act, motive and consequence, character and conduct." They assume that character and disposition are a growth, that the power to foresee and to desire consequences is a power that can be cultivated, and that conduct can be improved through profiting by experience, that is by paying attention to the consequences of the behavior of one's self and of others. As the character of a normal person grows, there is in that person an increasing recognition of the importance of the public or social good as contrasted with the satisfaction of mere personal or private inclinations. Activities that result in social good are duties, the performance of which by a growing self leads to the realization of the more ideal possibilities of character. The self of mere private inclination with its habitual tendencies makes place more and more for the self of reason that gradually develops as it takes account of unachieved possibilities of the natural tendencies that are socially helpful and intentionally strives to realize them. As growth proceeds, there is an ever greater expansion of the ends of the self and a continual reconstruction of the character. The problem of ethics is, therefore, the building, with the original instincts as a basis, of a character in which socialized desires and affections are the controlling elements and in which the love of things that makes this possible is adopted as a principle to guide reflective thinking. Virtues are the habits or traits of such a developed character; they tend to preserve and to enlarge the values that make human life rational and good. Vices are traits of character that have the opposite tendency. The ethical character involves justice and sympathy, courage and vigor, whole-mindedness, harmony, moderation, and self-control, as well as wisdom or conscientiousness—the "cardinal virtues" of moral theory. That the relations of mental hygiene to ethics must then be exceedingly intimate will be obvious. For among the tasks of mental hygiene are included (1) seeing to it that of the human beings born into the world more than hitherto inherit normal capacity for ethical development, and (2) seeing to it that the circumstances of education and experience are such that the development of virtuous traits of character are favored and the growth of vicious traits hindered. In how many ways the prosecution of these tasks by mental hygienists will concern family life, community life and national life, the future alone will reveal. But it is certain that any careful consideration of the relations of mental hygiene and ethics will lead thoughtful persons to realize that we have to deal here with fundamental problems of individual life and of social welfare.

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*Abbott, T. K. Kant's theory of ethics, 4 ed. Lond.: Longmans, 1889. Dewey, John, and Tufts, J. H. Ethics. N. Y.: Holt, 1908. Hobhouse, L. T. Morals in evolution. N. Y.: Holt, 1916. Mill, J. S. Utilitarianism. N. Y.: Longmans, 1901. Moore, G. E. Ethics. N. Y.: Holt, 1918. Paulsen, F. System of ethics; English tr. by F. Thilly. N. Y.: Scribner, 1908. Rashdall, H. Theory of good and evil. Lond.: Oxf. univ. press, 1907. Westermarck, E. Origin and development of the moral ideas. Lond.: Macmillan, 1912.

If mental hygiene is closely related to the science of ethics, it will easily be seen that it stands akin also to the science of *politics*.*

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*Aristotle. Politics; English tr. by B. Jowett. Oxf.: Clarendon press, 1908. Dunning, W. A. History of political theories. N. Y.: Macmillan, 1902–05. Jenks, E. History of politics. Lond.: Dent, 1900. Muir, R. National self-government, its growth and principles. N. Y.: Holt, 1918. Pollock, Sir F. Introduction to the history of the science of politics.. Lond.: Macmillan, 1916. Raleigh, T. Elementary politics. Oxf.: Frowde, For the science of politics deals with (1) the foundation and general constitution of the state (theory of the state), (2) the forms and administration of government (theory of government), (3) the principles and methods of legislation (theory of legislation) and (4) the state as a unit related to other similar units (theory of the state as an artificial person). Especially in countries where the people are self-governing is it important that the ideas, the feelings, and the actions of individuals in reference to the state, to government, to legislation, and to international relations should be matters of deepest concern. The world has had more than one example of the failure of institutions of self-government when the attempt to establish them was made prematurely. In order that self-governing institutions may cooperate successfully the people concerned must have had sufficient training to enable them to make good use of them, and they must be united enough in sentiments, aims and purposes, to cooperate more or less easily in the process of government by discussion. When the individuals in a community have not sufficient appreciation of the complexity of political questions, or when they have not been educated by practice to the necessity of compromising, of giving and taking, and of accepting the conclusions of the majority after thorough discussion, there is little likelihood that they will succeed in self-government. The habituation to teamwork after discussion in minor and local matters can alone provide the training that is necessary for self-government in the greater issues that affect the nation. Mental hygiene in the family, in the schools, in the community, in the nation, and in international groups, has therefore a great task to perform in habituating the people to unity of sentiment and to cooperation after discussion in the management of common affairs. If it be agreed with Huxley that government is the "corporate reason of the community" and with Burke that a state is "not a partnership in things subservient only to the gross animal existence of a temporary and perishable nature" but "a partnership in all science, a partnership in all arts, a partnership in every virtue and in all perfection," no one will be inclined to minimize the task of the mental hygienist in his relations to the political thinking, feeling and acting of individuals in democratic or self-governing communities. The peoples of the

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1886. Tufts, J. H. Our democracy; its origins and its tasks. N. Y.: Holt, 1918. Willoughby, W. W. Examination of the nature of the state; a study in political philosophy. N. Y.: Macmillan, 1903. Wilson, W. The state; elements of historical and practical politics. Rev. ed. Bost.: Heath, 1898.

world at the present time are witnessing the disastrous effects of a faulty mental hygiene through which a whole nation has been systematically educated to false political ideas, to erroneous conceptions of the nature of the state and of its relations to other similar political units. The undoing of the harm that has resulted from this pernicious education is proving to be the most gigantic task that has ever fallen to the lot of the self-governing nations. In the accomplishment of this task there is good reason to believe that self-government will more thoroughly than ever establish itself in the world, that it will steadily enlarge its range, and that after the war, a great partnership will be formed that will help to make life better not only for single persons and for single nations, but also for humanity as a whole.

The relations of mental hygiene to biology, to psychology, to sociology, to ethics, and to politics are, as we have seen, most intimate. If there were time, the importance of its relationships to a whole series of other sciences might well be discussed. Through a careful study of all these relationships to the more fundamental sciences upon which a science of mental hygiene must be based, we gradually arrive at a knowledge of what mental hygiene is not and of what mental hygiene is. We go far, too, toward collecting the data for a science of mental hygiene, data that are to be classified and reasoned about until the laws to which they conform can be discovered, whereupon utilities based upon these laws can be perceived. Machinery for making the adjustments necessary can then be devised, and these inventions employed by the practitioners of a new art of mental hygiene.

Now I can hear someone saying, that is all very nice and philosophical and broadminded and large-scoped talk about mental hygiene and its possibilities, but what is the concrete application? How can we do anything directly and concretely toward the realization of some such plan as has been outlined? Well, one might, if he were indiscreet, try to make a large organization right away, based on this wider conception of mental hygiene. In other words, in addition to our present Executive Committee, which is really a committee for applied psychiatry largely, we might have another committee (parallel with it) for applied biology, a third for applied sociology, and so forth, according to the number of fundamental sciences that we tried to apply. I can conceive of such an organization ultimately existing, but to try to effect such an organization all at once would be an unwise thing to do. If such an organization should ultimately come, then we could have an upper Executive Committee that would coordinate the activities of all these several special executive committees. But I am a great believer in small beginnings and in gradual growth. If our wishes are to develop as above, then let us use our intellects to direct our desires, look at the obstacles, see exactly what they are, and try to find paths around them toward this larger development. As a single, concrete, practical suggestion, I would ask our Executive Committee to consider whether means could not be found to engage, say, one well-trained, large-minded, sociologist, or one well-trained, large-minded psychologist, or one well-trained, large-minded biologist to prepare for us a comprehensive report upon the relations of his science to a science and art of mental hygiene. If we could, for example, induce a sociologist of the type I have in mind to give a part of his time for one or two years to a consideration of the bearings of sociology upon the specific problems of mental hygiene; if we could do the same with psychology, with biology, with ethics, and with politics, we should in the course of a few years accumulate information and ideas that would be exceedingly valuable as a foundation for further work, and I have no doubt that such reports would indicate the next steps that should be made. The appropriation for the purpose should be large enough to justify the undertaking of the work by important men with philosophic minds, men who have been thoroughly trained in their respective branches. Of course, the financial would not be the main reward for the kind of man we would want to interest in the work; his main recompense would be the satisfaction of employing his energies in work that he enjoyed and in contributing in an important way to the progress of science and of socialization. If brewers find it worth while to spend large sums to engage scientists to discover new methods that can be applied in their work, if the manufacturers of munitions find that it pays them to employ scientific men to study and solve their problems for them, if electricians find it advantageous to put a large amount of money into research laboratories, is it not obvious that we who are interested in mental hygiene must find the way to interest and employ scientific men in the consideration and the solution of the problems that we face?

I hope that what I have said will not be considered as depreciatory in any way of the work we have been doing in trying to apply psychiatry and neurology to mental hygiene. On the contrary, I have the greatest admiration for the work that has been done, and no one desires more than I do that this work shall be developed on a very much larger scale than has been possible as yet. Indeed, it is the very success of the efforts made in the application of psychiatry and neurology to mental hygiene that excites an appetite for similar successes in the application of still other sciences. Appreciating our present work fully, I am impressed with the importance of the other directions that I have referred to, and I hope that we shall be able soon to formulate some new plans that will accelerate progress in the development of a pure science, of an applied science, and of an art, of mental hygiene.

THE TRAINING SCHOOL OF PSYCHIATRIC SOCIAL WORK AT SMITH COLLEGE*

I. EDUCATIONAL SIGNIFICANCE OF THE COURSE

W. A. NEILSON, LL.D.
President of Smith College

THE situation which confronted Smith College last spring when it was proposed that it should undertake the training of psychiatric social workers contained two factors. In the first place, the trustees of the College, like those of its sister institutions, were eager to put their resources at the disposal of any branch of the Government which could show how to be of service to the country in the present emergency; and in the second, they were considering the more general and permanent problems of the duty of the College in the matter of vocational training and of the use of the equipment of the institution during the long vacation. The proposal of The National Committee for Mental Hygiene afforded an opportunity for an experiment dealing with both factors.

The first stage of the experiment has proved an unqualified success. Between sixty and seventy students were selected on the evidence of previous training and general fitness from a large number of applicants from all sections of the country. They varied in age from girls just out of college to experienced social workers in middle life. But they were all actuated by the desire to furnish themselves with a knowledge and aptitude which would enable them to help in salvaging the human wreckage of the war, and they manifested an acute intellectual curiosity as to the subjects studied. The course was intensive in the best sense. Students and teachers were in close and constant intercourse. The whole group was simultaneously interested in the same problems, and the intellectual interest was sharpened and maintained by the prospect of immediate practical application. The course was varied, containing lectures on general theory, study of the literature of the subjects of psychology, sociology, social case work and psychiatry, discussions of methods of investigation and record, laboratory work in mental tests, and clinical demonstrations. Thus the work was at once concentrated and varied, theoretical and practical, a gathering of information and a training in ways of thinking and acting. The outcome was an unbounded enthusiasm, showing itself in hard and persistent work and in the development of a remarkable *esprit de corps.*

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*The Training School of Psychiatric Social Work was established by the authorities of Smith College and the Boston Psychopathic Hospital under the auspices of The National Committee for Mental Hygiene, acting through a committee composed of E. E. Southard, M.D., Chairman, William L. Russell, M.D., L. Pierce Clark, M.D., Walter E. Fernald, M.D., and William A. Neilson, LL.D.

The course consists of eight weeks' instruction given at Smith College, July 8 to August 31, 1918, and six months' practical work at different centers.

The courses of instruction included Sociology under Prof. F. Stuart Chapin, Smith College, Psychology under Prof. David C. Rogers, Smith College, and Social Psychiatry under Dr. Edith R. Spaulding, Director, Psychopathic Hospital, Reformatory, Bedford Hills, N. Y. The practical work is under the general supervision of the Director of the Training School, Miss Mary C. Jarrett, Chief of Social Service, Psychopathic Hospital, Boston.

It is obvious that there were present conditions exceptionally favorable for an educational experiment: a variety in age, personnel, previous history, and in the range of studies; a homogeneity of interest and spirit; and an absence of distraction. The multiplicity of extra-academic activities which are thought necessary in the ordinary college course was absent, yet any visitor to the school was struck by the high spirit of the group almost as much as by the seriousness of the underlying purpose. When the six months of practical training which is now following the eight weeks of study are completed, there will be at the disposal of the Surgeon General a body of women eager, intelligent, devoted and exceptionally equipped.

All this has been accomplished at a minimum of expense. The College had no funds for the purpose, but provided class rooms, books, laboratories and dormitories. The students paid for their board and twenty-five dollars towards running expenses. The balance was provided by the generosity of Smith College alumnae. Teaching and administration service were offered free, wholly or in part, by members of the College staff; a large number of distinguished specialists gave their time and knowledge without other recompense than the sense of serving the common cause; and Dr. Houston added immensely to the value of the trainingby placing at the disposal of the school all the resources of the Northampton State Hospital, and by giving the services of himself and his colleagues in the conduct of clinical demonstrations.

Educationally, the undertaking has been fruitful and illuminating. We have learned that, even in an exceptionally hot summer, Northampton is an entirely possible location for a vacation school, and that for this purpose it has advantages over a great city in its quietness and isolation. We have had it proved that on the basis of a college training a highly specialized body of knowledge can be imparted in a surprisingly short time to students who know what they are to do with it and are accordingly eager to avail themselves of every opportunity. Others can speak with more authority on the importance of having organized the preparation for a new profession, a profession whose scope is by no means limited to war conditions. The College has its reward in having secured valuable evidence to aid it in solving the problem already stated—of doing its share in providing women with a worthy profession, and in making its equipment render an increased return in service to the community.

II. A LAY REACTION TO PSYCHIATRY

E. E. SOUTHARD, M.D.
Director, Boston Psychopathic Hospital

EACH of us who had contact with the Smith College part of the war course in psychiatric social work must have made his own differential reaction to it; at all events, nothing was more in evidence, I fancy, than individuality in theory and in practice this summer in Northampton. Besides the war fervor and the habitual zeal of young women in learning new things, there was a certain tone of maturity of point of view (and not too great or over-ripe maturity) on the part of these social work students that surprised a little those of us who were familiar with the atmosphere of social work conferences in the past. Here was post-graduate maturity, but on the other hand here were none of the peculiarities of the professional uplifter or reformer.

When I wrote my paper on "Mental Hygiene and Social Work: Notes on a Course in Social Psychiatry for Social Workers,"* I had no conception that the idea would come so quickly to fruition. Ferments, however, work fast these days and The National Committee for Mental Hygiene quickly appointed an appropriate subcommittee which was enabled, through the courtesy of the Boston State Hospital Trustees and the Permanent Charity Fund, Boston Safe Deposit and Trust Company, Trustee, to join with Smith College in a plan to get the didactic part of the teaching accomplished early in the summer.

It is a question whether men and women differ from each other or resemble each other so much as has been claimed in the past.

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* MENTAL HYGIENE, v. 2, p. 388–406, July, 1918.

We can safely assert about the present course, however, that the somewhat strong food of modern psychiatry and psychopathology got digested by our healthy young enthusiasts in quite the proper spirit. The results answered for all time the question whether certain publicities were permissible. Were these publicities practically impossible for so eclectic a group of women (some 70 chosen on experience, recommendations and internal evidence of letters), then verily the work of mental hygiene auxiliaries would have to be denied to women. There could not be a branch of psychiatric social work for women if women could not understand (and so to say *metabolize*) the main psychiatric facts as they affect society.

Accordingly, I regard it as a great achievement first, that so excellent a group of women came forward; secondly, that they could have been so successfully chosen from a larger group; thirdly, that they were able to get the main facts of social psychiatry without trace of evil reaction or discomfort. I am bound to say that with what I know concerning psychiatric instruction for medical students, these women got a fuller account of the general aspects of mental diseases than medical students in their third year ordinarily get in medical schools (of course, I do not mean to insist that what they got, though in some sense fuller, was in any sense an equivalent of medical instruction). Think how valuable for medical students courses in economics and psychology would be, drawn upon these lines. Social workers even talk of *socializing* the physicians and want to hasten the process.

There is room in the world for the nurse, for the occupation worker, and for that main stay of reform, the competent secretarial aid. There is room for the woman technician in bacteriology and other sciences, and no one doubts that there is room for the social worker. It seems to me that we can say already on the basis of the didactic part of our Smith College-Boston State Hospital course that there is room for the psychiatric social worker too. How many family problems have a psychopath as their central figure and nucleus no one knows who has not done practical work in this zone of advance. The best of it all is that these women have not only preserved their interest in the family, but have developed a wish to meet the psychopath and as it were "grasp the nettle." As the refrain of one of the Smith College songs this summer ran

"Be it ever so normal,
There's no place like home!"

III. THE COURSE IN SOCIAL PSYCHIATRY

EDITH R. SPAULDING, M.D.

Director, Psychopathic Hospital, Reformatory, Bedford Hills, New York

IT was not the intention of the training school to give to its students a complete course in psychiatry or to prepare them to diagnose or treat on their own responsibility the types of cases which were studied during the course. Its purpose was rather to teach the fundamental principles of human behavior both normal and abnormal, social and antisocial. With this end in view, the courses in psychology, sociology and social psychiatry all aimed to show the adjustment which is necessary if man's primitive instincts and desires are to find adequate and constructive outlet in the environment which modern civilization offers. The course in social psychiatry endeavored to show to what degree abnormal and antisocial behavior result from the inability to make such adjustment. Only those mental conditions were studied which have been found to be related to the war neuroses and psychoses.

The physicians who planned the course realized the responsibility of attempting in a period of eight weeks' time to teach a group of lay workers, without previous medical training, representing a wide range of ages, with a variety of educational backgrounds and various degrees of maturity, the principles of mental disease, in as thorough a manner as it might be done in our best medical schools. However, when all things were weighed in the balance, it was felt that the time of a world war and the need which was already being felt in our country as well as in others for trained workers of this type to assist in the reconstruction of returned soldiers were sufficient reasons to justify a method of procedure which in other times and under less pressing needs might be considered a risk. In spite of the fact that lecturer after lecturer looked for symptoms of mental indigestion they found only unflagging enthusiasm and a high pitch of interested attention, and seemed to agree with the visitor at the State Hospital who on seeing the class file through the corridor and not knowing who they were, remarked that most of them looked perfectly normal!

The different points of view regarding the origin of mental disease were presented even at the risk of causing some confusion in the minds of the students. At the same time, an attempt was made to eliminate all superfluous prejudice and unnecessary controversy, that the students might be left free to accept whatever their previous experience and knowledge would permit. However, the fact that they appreciated so keenly the type of men who lectured to them and the extent of their psychiatric training and experience unconsciously influenced them to overcome many of their resistances, thus allowing them to accept theories which, under other circumstances, would doubtless have taken a much longer time.

The school is particularly indebted to Doctor Houston, Superintendent of the Northampton State Hospital for so generously placing the facilities of the hospital at the disposal of students. The bi-weekly clinics which Doctor Houston held were one of the most important features of the course.

Ten and a half hours a week were devoted to lectures in psychiatry. This included two two-hour clinics at the Hospital and five lectures, some of which were an hour and a half in duration. The public was invited to attend one of the five lectures which was scheduled for Tuesday evening of each week. An equal amount of reading was supposed to supplement the lectures of each course. Although this was not strictly enforced in the course in psychiatry, still much outside reading was actually accomplished. There were twenty-six visiting lecturers, all of whom were so cooperative in contributing a definite part of a prepared schedule that the series of lectures was scarcely less consecutive than if it had been given by a single individual, and perhaps more diversified and stimulating. We should be glad to take this opportunity to express to the physicians who gave their time so generously our appreciation of their enthusiastic assistance. During the last week we were particularly fortunate in having Captain Bott and Captain Farrar, who came from Canada to give us the benefit of their long experience with the war neuroses.

The general plan of the course was as follows:*

First week: Physical causes of mental disease; demonstration by lantern slides of brain lesions; history taking and the mental and neurological examination of patients.

Second week: Epilepsy and the epileptic make-up.

Third week: Study of personality in general; hysteria, constitutional inferiority and psychopathic personalities.

Fourth week: Psychoneuroses.

Fifth week: Manic-depressive psychoses; alcoholism and the alcoholic psychoses.

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*A complete list of lecturers will be found at the end of this article.

Sixth week: Dementia praecox; paranoid states.

Seventh and eighth weeks: War neuroses and psychoses.

An important part of the course was a case history which each student was required to write according to the form given during the first week by Doctor Lowrey. It was suggested that the histories be autobiographies but this was left to the discretion of the individual. Many did write about themselves and some were able to describe and understand the complexes which had been influential in forming the trend of their lives. Others chose to describe abnormal mental conditions occurring in friends or in relatives. As a result of their newly acquired knowledge they were better able to understand conditions with which in some instances they had struggled for a period of years. The majority of these histories, it may be of interest to add, would have done credit to any of our psychopathic hospitals.

In looking back over the course it seems scarcely credible that the class could have assimilated so much in so short a time. However, thanks to their continued interest and enthusiasm, even the hot weather did not seriously interfere with their output of energy and the accomplishment of their task. The greatest strain seems to have been the continual readjustment of all their past experience and knowledge to new standards. But even this was said to bring with it a sense of contentment greater than any that had been experienced previously. We hope that the majority of the group gained a more tolerant attitude and greater sympathy toward abnormal behavior in general, and an understanding of the fundamental principles which will underlie the conditions to be found in the war neuroses and psychoses.

The first part of the course has been largely theoretical. The practical work is to come in the six months that follow. The ultimate success of the course, however, depends largely on the further cooperation of the psychiatrists in recognizing the ability of these specially trained workers, in giving them sufficient scope in exercising their ingenuity and in helping them to apply the knowledge that they will have acquired during their eight months of training. Above all, it is to be hoped that these social workers and others to be trained later in similar courses will be of invaluable assistance in the field of mental hygiene which has even greater possibilities than that of the very imperative but more limited field of the reconstruction of the soldiers who will suffer from the war neuroses.

List of Lecturers

Dr. E. E. Southard, Director, Boston Psychopathic Hospital
Dr. J. A. Houston, Superintendent, Northampton State Hospital
Dr. Lawson Lowrey, Boston Psychopathic Hospital
Dr. Clarence O. Cheney, Psychiatric Institute, Ward's Island, New York City
Dr. Everett Flood, Superintendent, Monson State Hospital for Epileptics, Palmer, Massachusetts
Dr. William Healy, The Judge Baker Foundation, Boston
Dr. James J. Putnam, Boston
Dr. Abraham Myerson, Boston Psychopathic Hospital
Dr. L. Pierce Clark, New York City
Dr. Adolf Meyer, Director, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore
Dr. George S. Amsden, Bloomingdale Hospital, White Plains, New York
Dr. H. W. Frink, New York City
Dr. H. A. Harrington, Psychiatric Institute, Ward's Island, New York City
Dr. A. A. Brill, New York City
Dr. Albert M. Barrett, Director, Psychopathic Hospital, Ann Arbor, Michigan
Dr. Ray Lyman Wilbur, President, Leland Stanford University, California
Dr. H. W. Mitchell, Superintendent, State Hospital, Warren, Philadelphia
Dr. George H. Kirby, Director, Psychiatric Institute, Ward's Island, New York City
Dr. Charles I. Lambert, Bloomingdale Hospital, White Plains, New York
Dr. T. H. Ames, New York City
Dr. Herbert Hall, Marblehead, Massachusetts
Dr. Walter E. Fernald, Superintendent, School for Feebleminded, Waverley, Massachusetts
Capt. A. E. Bott, Military School, Hart House, Toronto, Canada
Capt. C. B. Farrar, Cobourg Military Hospital, Cobourg, Ontario
Miss Betsey Libbey, Philadelphia Society for Organizing Charity
Miss Jessie Taft, Director of Social Service, Committee on Mental Hygiene, New York State Charities Aid Association
Miss Anna King, Executive Secretary, Home Service, American Red Cross, Boston
Mr. George A. Hastings, Executive Secretary, Committee on Mental Hygiene, New York State Charities Aid Association
Dr. Josephine C. Foster, Boston Psychopathic Hospital

IV. A SCIENTIFIC BASIS FOR TRAINING SOCIAL WORKERS

F. STUART CHAPIN
Professor of Sociology, Smith College

IT is small wonder that the vicissitudes of experience appear to the average person as a hopelessly disjointed sequence of chance events, but there is no excuse for an educational system to present knowledge as though each subject occupied a separate pigeonhole or an independent water-tight compartment in the scheme of things. And yet this is the impression that the great majority of students get. Our schools and colleges have presented the subject matter of knowledge in such a way as to disguise effectively the real and essential relationships between history, psychology, economics, biology, etc. It is only the keener minds that make the astonishing discovery that these subjects are but different points of approach to the same common problem of human relations.

The social case-worker follows a routine of fact-getting that views one case after another, and each as a unique problem in itself to be treated on its own merits. Hence the tremendous importance of supplying case-workers-in-training with a sound knowledge of the solid mid-ground of fact and principle which runs through all social relations. The information thus gained gives the worker with individual cases a vantage ground from which to view disinterestedly and coolly the relation of her individual effort to the general effort. It is then discovered that one's individual effort, which had so often appeared detached and aimless, may be made vital and immensely significant as part of the greater collective effort which stretches back into the past and reaches forward toward the future. One learns to know that when individual effort is detached from the collective effort, a social reverberation is set up which often entails disastrous consequences. All this information and mental discipline may be supplied by a fundamental course in sociology.

A course in sociology becomes, therefore, a *sine qua non* of preparing case workers by the method of the short intensive training course of the kind given at Smith College. Yet, although sociology synthesizes the work of other fields, it helps to develop a sound perspective towards social relations chiefly because its own special and independent field of study is the discovery of principles which operate in the growth and change of social standards, customs and traditions, while applied sociology (or social work) is the effort to prevent lapses from the prevailing standards of a time and place.

The economic aspects of our social problems usually appear fundamental, yet the searching analysis of psychiatrists as well as the sad experiences of social workers have demonstrated that below the surface of economic conditions lies the elusive psychological fact, and sociologists know that lower still may be found a stratum of biological fact and principle. The well-meaning social worker who underestimates the force of conventional standards of living and fails to solve her problem by economic means falls short because she neglects the momentum of custom and the psychological overlap of the past. Likewise, the energetic social reformer who legislates to restrict the employment of married women at confinement is likely to leave out of his reckoning the social reverberation of the law as seen in its deterrent influence on marriage and above all its discouragement of childbearing on the part of healthy married women who do work.

Social workers and social reformers need more of that "animated moderation" which comes from a knowledge of scientific method and scientific perspective towards action. The disinterested search for truth, the chief characteristic of the scientific method in action, may become fundamental in social work without loss of that sympathetic personal touch which has been the great contribution of the art of social amelioration. Ruling out the "uplifters," serious social work must on the one hand, lift its eyes from the routine of simple fact-getting to the obligation as well as the promise of a more complete scientific method and, on the other hand, must learn to cultivate a "noble discontent" with legislative action that is not intelligently checked up by impartial observation and thorough study of its consequences. Social case-workers become applied sociologists as soon as they cease to view their "cases" as a chance sequence of detached events and come to regard them as more than unique problems to be sympathetically and wisely solved, to view them indeed as scientific facts of observation contributed to the mass of trustworthy data which is some day to be assembled, classified and its true meaning formulated into some social law of universal validity.

It was an ambitious idea to endeavor by short-cut methods packed into two scant months of lecture, discussion and reading to develop such a point of view among our students. But the attempt was made. The stimulus of war-time needs and the ideals of social service, combined with the novelty of the plan and the unusual intellectual interest of the subject, conspired to originate at the start and to maintain without slump during the entire period a high enough morale among students and teachers to make the effort successful.

A sound knowledge of the biological backgrounds of modern community problems impresses upon social workers the tremendous importance of the hereditary equipment of the individual—for example, congenital feeblemindedness—and guards her against sentimental and unscientific methods which might tolerate the marriage and hence the multiplication of a type of person innately incapable of conformity to prevailing social standards. But instincts also are part of our native equipment and since instincts are the result of selection far back in the past of the race, they do not adapt men to the obligations and responsibilities of modern life and other conditions set by the restraining influence of custom. This state of affairs is reflected in the frequent mental conflict and social maladjustment of those who are in distress.

Thus the environment of a "case" is far more than its economic surroundings—it consists also of the social atmosphere of the community, a psychological background of prevailing standards, customs and traditions. Individual and collective effort that fails to appreciate that all economic and industrial phases of a problem have their backgrounds, basis and foregrounds in biologic and psychologic facts is likely to set going a train of far-reaching consequences that get beyond control. Hence all responsible individual and collective effort in the service of humanity must be based on knowledge derived from the use of those three principles of science, invariable for all fields of study—disinterested observation, systematic classification and inductive generalization.

In conclusion, then, the chief contribution of the Smith School from the point of view of sociology has been the satisfactory demonstration that training for social case-work may be based on scientific method rather than on philanthropic technique. The practical value and inspiration of such a discipline was abundantly proven by the testimony of experienced social workers who attended the school.

V. AN EMERGENCY COURSE IN A NEW BRANCH OF SOCIAL WORK

MARY C. JARRETT

Chief of Social Service, Boston Psychopathic Hospital

THERE are two main features of interest to the social worker in the Training School of Psychiatric Social Work, held at Smith College this summer, from the point of view of development in social work: (1) the fact that the course is preparation for a new field of work for which no formal training had previously been attempted and (2) the use of a new method of instruction by which the didactic work and practical work are given separately, one fourth of the course, or two months, being given to intensive instruction by lectures and clinics, and three fourths, or six months, to practice under direction.

In the past all training for psychiatric social work has been by the method of experience. The only attempt at systematic training was an apprentice course offered by the social service of the Boston Psychopathic Hospital to six or seven students at a time. The demand for especially trained social workers in this field has been far greater than the supply. The approaching problems of war neuroses made it clear that emergency training should be undertaken. The services of social workers in the care of mental and nervous patients, proved indispensable on a small scale here and there in civilian hospitals, would evidently be required on a large scale in the reconstruction program for military cases.

The plan of dividing the didactic and practical portions of the course was suggested as a practical necessity, for no one city could offer adequate opportunities for practice to forty or fifty students at once. The students of the Training School are now assigned to hospitals and social agencies in four cities, Baltimore, Philadelphia, New York and Boston. It is a question whether the method may not be theoretically as well as practically good, for there was distinctly an advantage, for acquiring both information and morale, in the intense concentration and application possible in a quiet, somewhat remote place like Northampton. The didactic instruction is to be continued to some extent throughout the period of practical work, through weekly or bi-weekly meetings of the students in each city with lectures from physicians and social workers.

Another matter of interest to the social worker is the general recognition of the importance of social work to the practice of psychiatry implied in the fact that the course was given under the auspices of The National Committee for Mental Hygiene and shown by the cordial cooperation of the large number of eminent physicians who came to lecture to the school.

The undertaking of training for social work by a great women's college such as Smith is significant of a growing belief that social work is tending to become a profession that will eventually demand academic and practical training comparable with education now required for the established professions. The students called out by the course made a high average in intellectual capacity. Forty-three were college graduates, the other twenty had been well educated in other ways, while four had done graduate work. They represented twenty colleges and came from twenty-one states. Ten were social workers who had done the required practical work and have received certificates for completion of the course. Forty-seven are now getting their practical work in thirteen different hospitals and social agencies under trained social supervisors.

During the period of practice the students will be grounded in methods of social case-work. Preparatory instruction covered the relation of social work to sociology and psychiatry, and the general technique of social case-work with some reference to special psychiatric problems.

Either in civil or military work, graduates of the school should be fitted (1) to secure social histories required for medical diagnosis, (2) to assist in the reeducation of patients in hospital if pressure of work upon the physicians makes such lay assistance desirable, and (3) to undertake the social readjustment of discharged patients.

VAGRANCY

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OF the 180 inmates examined at the Westchester County Penitentiary between February 2, 1918, and May 10, 1918, 44 or 24 per cent were charged with vagrancy. Of the remaining 136 charged with other offenses, there were six whose histories leave no doubt whatever of their being vagrants or tramps, so this presentation comprises a series of 50 cases, or 28 per cent of the whole number of inmates examined.

Before proceeding with the analysis of these cases, let me briefly present to you some material that I obtained in looking up the general subject of vagrancy. The term vagrant is Teutonic in origin and means to be unsettled, to wander, to walk about. The dictionary defines vagrancy as "wandering from place to place, roving with uncertain destination; moving hither and thither with no certain home." The ordinary meaning of the word vagrant is: "an idle stroller, a loafer, a vagabond, a tramp." In law the term includes much more than the ordinary usage implies; the object of the statutes being to subject to police control various ill-defined classes of persons whose habits of life are inconsistent with the good order of society. In English law the term is applied to unlicensed peddlers, beggars, prostitutes, fortune tellers, public gamblers, etc. In the United States the statutes are diverse but in general include to a greater or less extent beggars, drunken parents who refuse or fail to support their children, paupers when dissolute or sick, prostitutes, public masqueraders, tramps, train riders, etc. In our study, however, all of the cases were those who were out of employment and either had no permanent homes or had left their homes for various reasons and were wandering about the country.

The first mention of the word vagrant is contained in an English statute of 1547 where it is used synonymously with vagabond and loiterer. Blackstone, quoting an ancient statute, defines vagrants to be such as "wake at night and sleep by day and haunt customable taverns, alehouses and routs about and no man wot from whence they come ne whither they go."

In England in 1713 a law was passed reducing the laws relating to "rogues, vagrants, sturdy beggars and vagabonds" to one act for more effectually punishing them and sending them to their homes. The manner of conveying them included whipping them in every county through which they passed. However, vagrancy flourished in spite of this severe punishment, as it did when the punishment at an earlier date included death. Gradually the laws relating to vagrancy became less severe, leading in England to the establishment of the so-called "casual wards" where a man temporarily out of employment and traveling through the country might secure bed and board for a day or two in return for doing some work about the place, and to the punishment of vagrants by short terms in houses of correction, and on the Continent to the establishment of colonies. In this country the problem is handled largely by committing the person convicted of vagrancy to a term in a workhouse or jail for a period varying from one day to six months.

It is estimated that there are 500,000 vagrants in the United States, an army of nomadic, shiftless, homeless unfortunates. Many of them are in and out of penitentiaries and jails. Often they are taken advantage of by unscrupulous officials, especially those who are paid by the pernicious fee system.

No attempt, so far as I am aware, has been made by the medical profession in this country to investigate the causes and outline a treatment for vagrancy. I believe that our study will show how justified was the statement made by Dr. Varvaeck of Brussels, physician to the largest vagrant colony in the world, at the International Prison Congress in 1908, to wit: "that the interposition of the physician is at the basis of the treatment of vagabondism. He should examine the subjects carefully in order to find out the course of treatment best suited for them." In studying the literature on the subject I found that many laymen in this country had written articles dealing with causes and treatment of vagrancy. Most of these writers took no cognizance whatever of the medical aspects of the subject, attributing as causes economic conditions and the inherent perverseness of the individual.

In the study of our cases we had to depend for information almost entirely upon the statements of the vagrant himself. In a small number of cases additional information was received from state hospitals. We did not have the services of a trained social investigator. In fact, even if we had, I doubt if very much additional information could have been obtained in the majority of cases. Many of these cases came from other states; and many of them could not or would not give the address of any relative. The examination of each case included an inquiry into the family and personal history of the inmate, and a mental and physical examination. In cases where the procedure appeared desirable, an intelligence examination following the Stanford revision of the Binet-Simon tests was also made. This is a routine matter in all cases examined at the Penitentiary. The vagrants were not especially examined for the purpose of gathering material for presentation. On account of the number of inmates requiring examination it was not possible to devote much more time to each vagrant than was consumed in the ordinary examination. For these reasons I do not claim that this presentation is as thorough a one as it might be.

Regarding the ages of these fifty cases, it was found that the youngest subjects were nineteen years old. There were three of them.

9 were between the ages of 20 and 30;
6 " " " " " 30 and 40;
10 " " " " " 40 and 50;
11 " " " " " 50 and 60;
10 " " " " " 60 and 70;
1 was over 70 years of age.

In other words 36 per cent were under 40 years of age and 64 per cent were over 40. A study of the table shows that the younger subjects, those below 40, were more readily classifiable pathologically. Among them the feebleminded and the dementia præcox type of personality predominated. In the older subjects, deterioration processes predominated; but these were so mixed up with alcoholism and the inroads of advancing age that it was difficult in some cases to determine satisfactorily the underlying basic pathological factor, if any. In looking over these older men, wrecks tossed hither and thither, one wonders if something could not have been done earlier in their lives to make the path smoother for their old age, and whether it is not possible to outline a more beneficial procedure.

35 of the subjects were single;
3 were married;
3 were separated from their wives;
9 were divorced.

27 were native born;
23 were foreign born.

8 were of native parentage;
42 were of foreign parentage.

10 had no education whatever;
14 were barely able to read and write;
26 attended school for varying periods of from three to eight years.

It is very interesting to study the table of present and past sentences. We find that

11 were sent to the penitentiary for 1 month;
15 " " " " " " 2 months;
17 " " " " " " 3 "
3 " " " " " " 4 "
4 " " " " " " 6 "

and one adds the question, Why? Why are these men sent to the penitentiary? If the idea was punishment, society made a sad mistake. None of them looked upon a short sojourn in a penitentiary as a hardship. On the contrary many of them considered their sentences a matter of good fortune, especially during the cold weather. Was the aim rehabilitation? I doubt it, for the time allowed for that was altogether too short. What then is the answer? It seems to me that in some cases the purpose was simply to get rid of the man for a short time and in other cases to provide him with a shelter, not knowing what else to do with him.

The men confessed the following previous records:

22 said they had never been arrested before, but I doubt this very much in most of the cases;
13 said they were serving their second term;
6 confessed to three terms;
2 confessed to five terms;
1 confessed to six terms;
1 confessed to twelve terms;
1 confessed to eighteen terms;
1 said that he had been in Elmira once, in state prison four times and six times in penitentiaries;
1 said that he had been in Elmira once, had served three terms in state prisons and two terms in penitentiaries;
1 said that he had served a previous term in a state prison;
1 volunteered this astonishing information: one term in Elmira, three terms in state prisons and nineteen terms in penitentiaries.

What has society accomplished by all this? Think of the expense of the machinery installed by the commonwealth to apprehend and send these men to work on a stone pile for a few months, with practically no inquiry before sentence as to what kind of men society is dealing with, and very little effort until quite recently to help them after their discharge. The table of diagnosis will show how very much the medical profession should be interested in the solution of this and other problems in criminology. Medical men should take a deeper interest in the pioneer work of such men as Healy, Adler, Fernald, Glueck and others in this country. These men are engaged in clearing the land and providing an attractive field where much good work of real value can be accomplished. Then, too, the work is yet largely experimental and these men are now in a sense on trial. The medical profession is likewise on trial, so it behooves us to take an interest in this work to see to it that it is not allowed to flicker out through sheer indifference. This is the medical man's work, and whether it shall be turned over to him 10, 25 or 50 years from now depends upon how thoroughly the work is done now and how much the profession in general interests itself in the problem. A large part of the work should be done before the man is sent to prison, not after. It rests with the private practitioner, as to how well he is prepared to give advice on this question, whether we shall devote our time to the man before or after conviction. Now let us examine our subjects to see what kind of material we are dealing with in vagrants:

7 were feebleminded;
1 was a borderline case;
14 were insane or were victims of the deteriorating process of a mental disorder;
1 was a psychopathic personality, semi-insane, an inventive crank;
1 was a drug habituate;
8 were chronic alcoholics;
7 showed senile deterioration;
3 were deteriorated, cause not definitely ascertained;
8 were unclassified pathologically.

Of the 14 more or less insane, three were definite cases of dementia præcox; 7 were either incipient cases of the same disease or showed deterioration from a previous acute attack; one was the victim of an acute alcoholic hallucinosis; one was the victim of a chronic alcoholic hallucinosis; one was a general paretic; and one was an epileptic with deterioration, who had escaped from a state hospital a month previous to his arrest for vagrancy. One of the dementia præcox cases had been released to the custody of a relative by a state hospital for the insane in another state. It is found by analyzing this table that at least 38 cases or 76 per cent showed definite mental pathological conditions. This fact points strongly to a medical approach in handling this problem. Let us compare these findings with those of other observers: Wilmanns of Heidelburg examined 120 old professional tramps sent to a hospital for the insane and found that 104 of the 120 were of long standing, unrecognized types of insanity. Bonhöffer in an examination of 404 chronic vagabonds found 74 per cent mentally unsound; at least 53 per cent were feebleminded, 60 per cent were chronic alcoholics and a number were epileptics. According to Ziehen at least 30 per cent of tramps are of a hereditary degenerate, psychopathic constitution.

Let me cite briefly a few individual cases so that if possible a more vivid picture may be had of the material in question:

Case No. 1. A man who was sent to the penitentiary for 90 days. He is 36 years old; was born in this country; is single. He has no permanent home and does not know the address of any relative. All the information he could give about his family was that his father worked in a coal yard, and that when the inmate was ten years old his father placed him in a home along with his brothers and sisters. He remained in the home for seven or eight years. He found school work too difficult, so spent most of the time in the institution, "cleaning around." He cannot read or write. After leaving the home he worked on farms for a time, earning $4 or $5 a month. Once he worked for a policeman, caring for horses at $3 or $4 a week. He has spent most of his time about the city dump, hunting for pieces of metal which he sells to junk dealers. When he has money he lives in cheap lodging-houses. He has no friends or associates and spends most of his leisure time sitting in a chair in a lodging-house. He has served eight or ten sentences for vagrancy in the penitentiary on Blackwell's Island. He is inferior in his general appearance and has a marked speech defect—stammering. He has very little grasp on matters of general interest, and intelligence tests reveal that his mental age is 8 years. Clearly a case of feeblemindedness. He was happy and contented in the penitentiary and was faithful at his work, which consisted in cleaning and mopping rooms and corridors.

Case No. 2. An inmate 31 years of age; born in this country; single; sentence 2 months. He says that his mother died when he was a young boy and that his father, who is a hard drinker, is now ill with Bright's disease. The inmate attended a school for three years and is able to read and write a little. He worked with his father off and on in a celluloid factory as a laborer and gave his father most of his earnings. He left home for no apparent reason a number of times and travelled about the country, begging his food and sleeping out of doors or in barns. He thinks he has been arrested about a dozen times. The last time he left his home his father became angry with him, because the inmate spent so much money for drink and, after threatening him several times, he finally took him to a railroad station, bought a ticket to New York City and placed him on the train and told him never to return. He made his way to the home of a cousin in New Jersey and worked for him for a short time. His work apparently was not satisfactory because the cousin hired another man to take his place. When this happened, the inmate decided to walk back to his home in Massachusetts. He was on his way when he was arrested. He is childish in action and speech, and is obviously feebleminded. Intelligence tests show that his mental age is but little over eight years.

Case No. 3. Fifty years of age. His father died of drink. His brother has been a patient in the Hudson River State Hospital, at Poughkeepsie, for a number of years. A nephew is soon to be committed to an institution for the feebleminded. He went to school for a number of years and is able to read and write. He converses with fair intelligence on ordinary subjects. He has always worked as a laborer, and in times past with a fair degree of steadiness, but during the past fifteen years—since the death of his mother—he has done odd jobs and has spent most of his earnings for drink. He has served three terms in the Westchester County Penitentiary since its opening, one year ago. On the second term he was released from the penitentiary on December 26, 1917. He walked to Elmsford, but before he was ready to take a trolley to his home town, he became intoxicated. He continued to drink and was sent back to the penitentiary on December 30, 1917, for a term of three months.

How long is this process to be continued? How much benefit has society and the inmate received from his commitments? Is there not a better way to handle this problem?

Case No. 4. Forty-three years of age. Born in Hungary. Although he has been in this country 5½ years he cannot converse in English. In Hungary he worked on farms. He came to this country because he heard that he could make more money here. For the past 4½ years he worked in a steel mill in South Bend, Indiana, but was forced to give up this job because fellow workmen made remarks about him and accused him of being responsible for the war. When people on the street took up this matter, he fled from South Bend. But he could not escape his persecutors, they followed him in airplanes and zeppelins and tried to kill him with electricity. He walked from one place to another trying to elude his pursuers. He begged food and slept out of doors. When he reached Westchester County he was arrested for vagrancy, an officer finding him asleep by the roadside. He is clearly a case of paranoid dementia praecox.

Case No. 5. Forty-two years of age. His family history is not otherwise significant than that a sister died of pulmonary tuberculosis. He attended school for several years. He was interested in his school work and progressed with average ability. He converses with fair intelligence on matters of current interest and retains his school knowledge fairly well. He worked steadily on farms and in a shoe factory until about twelve or fourteen years ago. At that time he was led to give up his job in the shoe factory and come to New York City, expecting to make more money as an employee of the street railway company. He worked for a few months at three or four different jobs, but did not seem to be able to hold any of them. He then became ill and was laid up in a hospital for several weeks with typhoid fever. After he recovered he returned home and remained on the farm for a few months. When he felt stronger he went to work as an assistant boss in a livery stable. He left this job because he could not get along with the other men. Then he returned to the shoe factory but was not able to hold this job for longer than five months; he does not know why, except that he felt weak and sick. Following this he remained in the shoe factory town but did not do any work for a year. He then went to New York City again expecting to go to work, but he spent another year in idleness living on money that he had saved up in former years. When his money gave out he applied at a police station for lodging and was sentenced to a penitentiary for vagrancy. Since his release from the first penitentiary, he has walked about the country. Sometimes he works on farms, but says that he never seems able to collect the full amount of his wages. He does not correspond with his family. He has served a number of terms in penitentiaries for vagrancy.

I classified him as a case of deterioration on a dementia praecox basis. It would have been very interesting to have examined this man during the period when he first felt unable to do any work.

Case No. 6. Thirty-five years of age; born in the United States of native parents; family history negative. He attended a public school irregularly from his seventh to his sixteenth year. He was able to learn readily but had a tendency to be truant. His father married a second time in 1896 and since then the inmate has been in trouble more or less. As a basis for his misbehavior, he has stated in the past that his stepmother influenced his father against him. He has admitted that in his trouble with his stepmother he did many foolish things. At one time he put laudanum in the food. For his continued misbehavior at home, he was sent to the State Industrial School in Rochester, where he remained for fifteen months. He was so unruly there that the authorities transferred him to the Elmira Reformatory, where he remained for two years. In Elmira he was in more difficulty and was disciplined a number of times; finally he threatened to commit suicide and was sent to the Matteawan State Hospital. He was discharged from that institution in May, 1902. He did not work regularly, associated with bad characters and acquired the habit of taking heroin. He was arrested in a raid on a drug resort and was sent to the Albany County Penitentiary. From that institution he was again sent to the Matteawan State Hospital, where he remained for three years and was released on habeas corpus proceedings. Soon after he was sentenced to Sing Sing for a term of three years for burglary. Later he was sentenced to the government prison at Atlanta. After his release from Atlanta he was again sentenced to Sing Sing for burglary. At one time he was in the hospital at East View suffering with a tubercular infection of the glands of the neck. He works irregularly and often tramps about the country. At the time of examination he was in good physical health. He is somewhat childish in his manner. His answers to formal mental tests and his knowledge of matters of current interest eliminate a diagnosis of feeblemindedness. His memory is not good regarding important matters connected with his past life. He does not express any delusions or hallucinations. He was unable to give any explanation for his continued antisocial career. It seems to be clear that this inmate is a victim of a dementia praecox process.

Case No. 7. Forty years of age; born in the United States of native parents. His brother has been a patient in the Dannemora State Hospital (criminal insane) for a number of years. He cannot give reliable information about his early development or education and is uncertain about his occupational career. For a number of years he has been tramping about the country because he felt he was in danger of purgatory and thought he had to die for sinners; he did not want to die, so went from place to place trying to escape his fate. He believes that somebody hypnotized him. Sometimes he hears voices but cannot remember what these voices say to him. In 1909 he was found wandering about the streets of Rochester and was committed to the Gowanda State Hospital. There he was very silly in his actions and said that he was Jesus Christ. He escaped from the hospital in 1910. Since then it appears that he has been wandering about the country and has been in and out of penitentiaries. For a time he was in a hospital suffering with pulmonary tuberculosis. At the time of examination he presented evidences of this disease. A Wassermann test was made and was found to be four plus. For the past eight years this insane man has been wandering about the country. He is an additional menace to the community because of his tuberculosis and syphilis.

The senile cases are unmistakable. All of them were men of advanced years and many of them had physical disabilities in addition to their increasing senility. Some of them in the past had been faithful workers and had lost their positions with the decline of their efficiency. Two of them who were released from the penitentiary were returned within a few days, again charged with vagrancy.

I should like to present the history of all the cases that I examined at the Penitentiary, but this would take up altogether too much time. I trust that a sufficient number has been presented to give you some idea of the kind of men that go to make up most of the army of vagrants.

With some notion of what material enters into the problem of vagrancy, what solution are we going to suggest for it? In this connection let me quote Dr. Varvaeck again. He says: "It is useless to spend so much money in reforming vagabonds and beggars if we leave them without moral support when they are released and thrown back into common life. Only those should be released who are capable of self-support. The infirm should go to hospitals. The man who means to regain his place in society should be placed in a shop or factory and entrusted to some one who will look after him—a member of a guardian society. It will be his duty to follow the man, to counsel him, to stand by him in his trials and to inspire him with self-respect and courage, that he may persevere in the hard road he has to follow to regain his place in the community."

The continental European countries have adopted the colony system in caring for their vagrants. The officials of the Swiss

Colony feel that the colony has been successful because fewer and fewer vagrants are returned to it. One writer believes that the reason for this is that after eighteen months or two years in the colony, habits of industry are instilled into the men, and that they find it easier to take up work outside.

For the insane there is an established procedure. For the feebleminded also, except that the available institutions are crowded and they do not care to receive criminals. The procedure in the case of this class will be simplified when the institution for the feebleminded delinquent is established by the state. Many of the older men should be sent to county houses or, where the deterioration is profound, to a state hospital. For the remainder, it seems to me that a colony under medical supervision would be a step far in advance of the present custom. Commitments to such a colony should be for an indefinite period, and the parole of an inmate should be determined by his record for industry in the colony and by his physical condition. After parole it should be the duty of an after-care agency to follow the man closely, to give needed advice and encouragement, and to move for his return to the colony if habits develop which tend to impair his efficiency. The colony should embody features of the farm and workshop and thus offer every advantage to the inmate to acquire in the colony contacts designed to enable him to cope successfully with conditions in the outside world. Special attention should be given to the physical health of the inmates by systematic exercises and the correcting of any incapacitating factors such as vision defects, hemorrhoids, hernias, etc., of which I found quite a number. The men should be turned out in the best possible physical condition.

It is urgent to give this subject serious attention now, for careful observers have declared that vagrancy increases enormously after great wars. It is highly probable that this conflict will not prove an exception; on the contrary, considering the number engaged in the conflict and considering the mental and nervous strain to which the men are subjected, many will return to their homes with their minds permanently impaired; while others, restless after the excitement of active military life, will not be able to settle down to peaceful pursuits. Therefore, the proper handling of this problem may be a *post bellum* patriotic duty.

SUGGESTIONS IN THE NOMENCLATURE OF THE FEEBLEMINDEDNESSES

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THE First Epistle to the Thessalonians asks us, in Tindale's version of 1534, to "Comforte the feble mynded" (5:14). Upon looking at the original Greek, however, it would seem that St. Paul had reference rather to faintheartedness than to feeblemindedness in the modern sense of the term. In point of fact, the term imbecile, in its modern connotation of limited intelligence, was in much more frequent use at an early date than the term feeblemindedness, and the term imbecile was certainly in far less frequent usage for the poor in intelligence than the term idiot. De Quincey, in 1846, for example, puts the term imbecile in quotation marks, remarking of a person that he "had the misfortune to be 'imbecile' . . . in fact, he was partially an idiot."

It would be a pretty inquiry and one which would reflect in a delicate way the progress of mental hygiene, to study the history of these three terms—idiot, imbecile and feebleminded—down to modern times. Murray cites the *Daily News* of 1892 as still putting the term "feebleminded" in quotation marks. Feebleness of mind in the early usage of the term certainly did not restrict itself to the intellect. Imbecile was a term almost equally appropriate to the body as to the mind. The original significance of the term idiot is not at all close to the meaning of the present day. However, very early in the history of modern English, a man could will something to his "idiot," meaning thereby, his fool.

I have no design here to discuss the history of these terms. Suffice it to say, the term idiocy appears to be the most deeply established of all three terms. The term imbecile is now a close second thereto. As to the term feebleminded, a term still in some doubt as to whether it should undertake to spread over imbeciles and idiots as well as over the feebleminded "proper," American and English usages are not at one in the matter. I fancy that lay American usage would agree with lay and professional English usage. If one as a layman spoke of a feebleminded person, he would probably not mean an imbecile and would almost certainly not mean an idiot. Yet the search for an inclusive term for idiots, imbeciles, and the feebleminded proper has been a constant one.

In the public service and in legislative documents, provision for the feebleminded has come to signify provision not only for the feebleminded proper in the English sense but for imbeciles and idiots. In fact, I think there can be no doubt that the natural euphemistic tendency of man (this tendency ought to be subject to keen psychological analysis by some one after the war) has tended to the overuse of the term feebleminded simply because the terms imbecile and idiot seem too strong to employ. One did not care to call a spade a spade particularly when by skillful work the instrument could be made into something higher and better; in short, schools rather than asylums for the feebleminded, including imbeciles and idiots, were founded under the influence of their great teacher and promoter, Séguin. By these schools it was hoped so to improve these wards of the state that they would be self-supporting or even in some instances capable of citizenship. Moreover, these promises were well met now and again. The medical and educational professions doubtless never went so far as the laity in their hopes. However, it was always easier to wring from the unwilling public purse money for a school than for a custodial building.

Now, with the progress of the world, even the term feebleminded has become much too strong a term to use of many persons whom we tend to put together as subnormal. It is all very well to term imbeciles and idiots simply more and more pronounced and maximal examples of feeblemindedness. There is a certain logical justification for supposing all three of these groups, idiocy, imbecility and feeblemindedness proper, to fall into a quantitative scale from intelligence almost zero up to a stage corresponding roughly with late childhood or early adolescence. But what about persons whose mental tests and whose general worldly capacities signify that they are only slightly subnormal? What a shock to the layman's mind to hear these slightly substandard persons termed feebleminded! How little their brains in general appearance are removed from normality! How apt we are to think that by a slight turn of the endocrine glands, by another twisting of the wheel of fortune, or by a little more intensive education, these substandard persons could be made proper inhabitants of the world, proper voters, proper parents! Moreover, do not the mental tests if they signify anything, indicate for some of these substandard persons that they are not at all below the subaverage subjects that we are quite willing to call normal? That layman who makes a profession of being such and is most intensively a layman, namely, the social worker,.is equally at a loss. Nor can we omit to observe a number of lawyers and even judges floundering in a morass of doubt, when it comes to calling these slightly substandard subjects "feebleminded."

In short, is it not a truism in modern mental hygiene to say that there is now a new group of (as it were) superfeebleminded above the group of the feebleminded proper and far above the imbeciles and idiots? In short, on the psychometric basis and on the basis of everyday accomplishment in the world, do we not acknowledge that substandard persons, definitively below the range of the normal and probably incapable of reaching normality, fall into four compartments? To be sure, these compartments intergrade with one another so that one could not say where one leaves off and another begins. These intergrades are often possible to the extent of our admitting low, middle and high idiots, low, middle and high imbeciles, low, middle and high morons (as the feebleminded "proper," owing to the neat verbal contribution of Goddard, are now called). Whether anyone would desire to distinguish these persons that lie between the morons below and the normals above into three such groups, I question; but with finer diagnosis doubtless that distinction may be arrived at.

Accordingly, we now distinguish idiots, imbeciles, morons and a subnormal group as yet unnamed. We distinguish idiocy, imbecility, moronity (if this somewhat barbarous abstract term be allowed; it is preferred for lack of a better by many specialists), and the fourth unnamed kind of abnormality.

I want to argue for a new term to cover not merely the unnamed slight degree of subnormality which lies above feeblemindedness proper, but a term which shall cover all of the feeblemindednesses. I want to propose a term which shall include idiocy, imbecility moronity and any other forms of subnormality of intelligence which may be described. The literature is filled with the wreckage of such terms. I need only refer to David Hosack's book, *System of Practical Nosology*, published in 1819, wherein *amentia* (De Sauvages), *morosis* (Linnaeus), *stupiditas*, *amentia* (Vogel), *amentia* (Sagar), *amentia* (Cullen), *fatuitas* (Crichton), *idiotismus* (Pinel), *amentia* (Hosack) appear. From such a list it might well appear that the term amentia ought to be the term of election, and that term has been favored by many English writers. Owing to the proposals of Meynert concerning an acute mental disease characterized by the temporary loss of sundry faculties, the term amentia has, in American usage at all events, not been confirmed. In some ways I would wish that it could have been confirmed, though both amentia and its companion term dementia are subject to somewhat graver doubts than many other terms in psychiatry. Partly the usage by Meynert and partly the difficulty in quickly catching by the ear whether one is referring to amentia or dementia, will probably lead to its lack of permanent establishment in the literature, although I for one would rather like to be able to use the terms ament and dement under appropriate conditions.

Latterly, Kraepelin has proposed the term *oligophrenia*, and in a long chapter in his last edition he describes all forms of idiocy, imbecility and feeblemindedness under this term. There is, I believe, a slight postclassical Greek justification for the use of the term; still the prefix *oligo-* ought to refer to number, and the phrase ought to mean "few mindedness" rather than feeblemindedness. The only term in common usage with this prefix *oligo-* is the term oligarchy, which, in contradistinction to monarchy and democracy is a term that has come to stay. The connotation "few" rather than the connotation "slight" has certainly been attached to the prefix *oligo-*, and the denotation of this prefix is that of number. It should certainly be used under conditions where the cardinal number of elements is diminished by so and so many units.

There are no such rigid rules to which one need conform in medical nomenclature as in botanical and zoological nomenclature. Kraepelin's choice of oligophrenia is one of a long list of such choices by various eminent alienists. It seems to me that the term will not survive against the denotation and the usual connotation of the prefix *oligo-* therein. Kraepelin, it is to be regretted, has not been especially happy in the choice of terms for those syntheses of diseases which he has attempted to make. One cannot concede with pleasure—I doubt if we can concede at all—that the term manic-depressive and the term dementia praecox will survive a century. It would seem that Kraepelin has tried to make viable in some of his chosen terms certain features of the diseases that he has attempted to synthesize and has produced terms often both ungainly and inaccurate.

The deuterotheme of Kraepelin's term, namely, *-phrenia*, has a much happier suggestion. This term in the Greek usage appears pretty constantly to refer to the intellect rather than to the emotions and the will. We see being built up in psychiatric nomenclature a tendency to using as the themes of new terms for diseases that acquire a modern alignment the following deuterothemes:

-phrenia
-thymia
-boulia.

These terms are used for the intellect, the emotions and the will respectively. I think we can hardly do better than try to put the stamp of general approval upon the use of these themes in new terms, provided that we have nothing better to substitute for the corresponding old divisions of the mind into intellect, emotions and will, into thinking, feeling and doing.

As for the protothemes in psychiatric nomenclature, we have long had at our disposal the Greek *hyper-*, *hypo-*, *a-*, *para-*, to signify respectively degrees of alterations of disorder. Hardly any psychiatrist can fail to have been impressed with the logically beautiful usage of these prefixes by Wernicke, and his use of the prefixes was palpably borrowed from the general usage of neurologists to indicate degrees, for example, of sensory disorder (hyperesthesia, hypaesthesia, anaesthesia). Accordingly we could construct the following table by combining these prepositional prefixes with the deuterothemes above mentioned, and in so doing we should do hardly any violence to modern tendencies in nomenclature.

Hyperphrenia	*Hypophrenia*
Aphrenia	*Paraphrenia*
Hyperthymia	Hypothymia
Athymia	*Parathymia*
Hyperboulia	*Hypoboulia*
Aboulia	Paraboulia

I have italicized in the above table terms which either have come into common use or might as well come into common use. Inasmuch as most mental disorders run to diminution rather than to excess, hyperphrenia and hyperboulia will prove less useful in nomenclature. Possibly hyperphrenia might refer to intellectual geniuses.

In this note I have no idea of offering a complete nomenclature for psychiatrists; in fact, it would seem to me that the points made are quite obvious and wholly in the order of the day. But I would like to emphasize the great value of the Hellenic nomenclature on account of its neatness, its present usage, and its capacity of exact definition.

Is not the term hypophrenia one quite at our hand for any and all degrees of feeblemindedness? The term on account of the intellectual significance of the ending *-phrenia* will pin us down practically to the psychometric or intelligence-tested group, so important in modern school, court, hospital, dispensary and other social circles.

By the use of the term hypophrenia and its adjective hypophrenic, we shall avoid making the invidious suggestion that a subject is a moron when what we mean is that he is merely slightly subnormal and really a supermoron, or, as someone has suggested, a sophomoron. In court, in school, in hospital wards, in out-patient consulting rooms, our lack of tact sometimes permits us to speak of sundry persons as feebleminded when they are above the grade to which that term is ordinarily assigned. Is it not better to adopt a Hellenic term constructed in consonance with modern nomenclatural tendencies—a neat, brief term capable of exact definition and without any invidious or damaging connotation? Week after week it seems to me I have seen physicians and others quite lose their *rapport* both with relatives and with patients, when the term feebleminded is imported into the discussion. Nowadays we are demonstrating mental disease and defect to students in training, to psychological workers, to social workers, to court workers, to school teachers, and indeed to the laity at large. Will it not be better for us to adopt a term with an exact denotation and without injurious connotation?

I therefore suggest, as in certain previous papers, the term hypophrenia for the various feeblemindednesses both (a) slight subnormalities, (b) feeblemindedness proper or moronity, (c) imbecility, (d) idiocy. For the art or science dealing with the hypophrenias I would propose the term hypophrenics. Other compounds and usages will readily suggest themselves. The various hypophrenias form as it were the genera in the order of the feeblemindednesses.

VALID USES OF PSYCHOLOGY IN THE REHABILITATION OF WAR VICTIMS

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THE CANADIAN SYSTEM EXAMINED

THROUGH the efforts of the Red Cross Institute for Crippled and Disabled Men, in New York City, established by the philanthropy of Mr. Jeremiah Milbank, a group of officials and teachers from the United States was recently given full opportunity by the Canadian Government to study its system for the rehabilitation of returned disabled soldiers and sailors, in the hospitals and industries of Canada. Cooperating efficiently in this journey of instruction were Dr. Charles A. Prosser, Director of the Federal Board for Vocational Education, and representatives of the Surgeon General's Office, the United States Employees' Compensation Commission, the United States Bureau of Labor Statistics, etc. Members of the party were enabled to record the results of practical observations concerning numerous phases of rehabilitation in Canada, namely: Dominion and Provincial systems of organization and control; comparisons with similar plans in England, France, Germany, etc.; contemporary practice in Canada with regard to invalid occupations, curative workshops, occupational therapy, functional reeducation, etc., while the patient is under military control, and courses of study or content of instruction for various vocations and trades, which are made possible in Canada for the discharged soldier under the auspices of the Department of Soldiers' Civil Reestablishment. Information was gained in well organized conferences in the different cities of Canada, and by preliminary and parallel reading and also, for some members of the party, by the introductory studies and inspections made at the Red Cross Institute for Crippled and Disabled Men, in New York. All this information was excellently supplemented by practical demonstrations of various activities in Montreal, St. Agathe, Toronto, Winnipeg, Saskatoon, Edmonton, Calgary and Ogden.

Systems of record keeping were studied both at the central offices in Ottawa and also at the Provincial and local offices. Considerable attention was devoted to the prevailing methods of examining men with reference to possible training and occupational aptitude, as well as to the specific equipment and devices utilized in occupational therapy, functional reeducation and in the different phases of occupational training—be it general, elementary, or commercial, or trade. The industrial survey as to methods and with examples was studied. Some scrutiny also was given the qualifications and selection of assistants, teachers, and directors in Canada, whether they were engaged in therapeutic or in the definite occupational activities. The present status and potential influence of the Great Veterans' War Association was one problem under consideration. Conversations with returned soldiers and conferences with groups of officers facilitated the endeavor to understand the previous experience of the returned man, his desires, memories and present mental attitude.

Throughout the journey many Canadian citizens and officials, military and civil, gave efficient assistance at every turn, and also manifested a spirit of neighborliness and of appreciation. The visitors from the United States in Canada both as guests and also as pupils will long remember the hospitality and the well organized instruction received from Canadian officials and citizens. Indeed, the journey brought out very clearly, and deepened in an unmistakable manner in the minds of scores of representative men and women gathered at conferences and at dinners, the conviction or resolution that citizens of Canada and of the States are no longer mere neighbors, or even "cousins" but now and hereafter "we are and shall be brothers." Military and civil officials, educators, social workers and citizens in general demonstrated an interest in our mission.

During the progress of the journey, the conductor and instructor of the group, Dr. J. C. Miller, suggested to the writer as a psychologist with some industrial experience the preparation of a special report upon the psychological aspects of rehabilitation. Viewed from the standpoint of modern psychologists, e. g., James, Hall, Thorndike, Titchener, Myers, Pillsbury, Franz, Judd, Angell, Seashore, Yerkes, Terman, Whipple, Binet, Wundt, this is a difficult assignment under any circumstances, but especially under the conditions of the journey. Adequate opportunity was not possible to enable the cooperating members of the group to follow simultaneously the studies of administration, finance, organization, instruction and treatment, and at the same time to devote sufficient special attention to any one phase as, for example, the existing equipment and methods for psychological work in Canada, and to the making of necessary case studies. To gather reliable data and prepare a report of value upon this one topic, i. e., the psychological aspects of rehabilitation, would require special arrangements and necessitate the writing of a careful monograph. In response to the suggestion, however, we are recording herewith some of our impressions and some established facts concerning five groups of topics: (1) General applications of psychological principles; (2) brief accounts of eight Canadian cases; (3) educational applications of psychology in rehabilitation work; (4) the question of mental tests; (5) summary concerning rehabilitation. Chapters, of course, could be written concerning many other important phases of the Canadian system, as concerns organization, buildings, equipment, personnel, courses of study for returned soldiers, methods of the industrial survey, etc.

GENERAL APPLICATIONS OF PSYCHOLOGICAL PRINCIPLES

The soldier himself is the central object of study and of ameliorative effort. Fads and hypotheses, be they military, economic, medical, educational, or psychological, have no warrant in the activities of rehabilitation. Attempts to prove, disprove, or to exploit anything for its own sake, that does not conduce to individual and social rehabilitation, are to be resisted in this work. In the use of applied psychology where scientific developments have been comparatively recent, and where practical applications are at best tentative, many useless survivals of error are to be found, and caution must be used. This is also true even in the field of medicine, for today in the medical colleges of America, except in a minority such as Harvard, Johns Hopkins, Pennsylvania, etc., provision for scientific training of prospective physicians in experimental psychology is as a rule inadequate. Outside of the medical profession amateurs in psychology, cranks, cultists, and charlatans abound, and they must be rigorously excluded from opportunity to exploit soldiers in the name of "psychology." The soldier must be protected also from two other groups: There is found occasionally the highly trained man of research who is so absorbed in some special problem that he is unconscious of human values; and there is the otherwise competent doctor, executive, or teacher, who presents an attitude of hostility to general or special applications of psychology because he has no knowledge of scientific developments in that field.

Phrenology, chiromancy, telepathy, spiritism, "new thought," necromancy, mesmerism, etc., are wrongly associated with the word psychology in the minds of many persons. The science of psychology makes slow progress because of four facts: (1) Every one possesses a crude psychology of his own, for in everyday life he must understand the conventional meaning of instinct, memory, habit, will, dreams, etc. (2) Scientific psychology touches these matters in so far as it is able to explain the illusions and the deceits of phrenology, chiromancy, telepathy, mesmerism, etc., and is therefore easily confused with them. (3) It has not been possible to prevent the dishonest and the untrained from posing as psychologists. Law, medicine, the ministry, have encountered similar professional difficulties. (4) It has proved true that ruthless psychological methods of analysis and experiment have run counter to some intrenched superstitions in medicine, theology, education, and sociology.

In a sense, every phase of activity to rehabilitate the returned disabled soldier is a psychological problem. It is essential to understand the mind and the experiences of the soldier in the transformation that he has undergone. Efforts to rehabilitate the disabled returned soldier will fail without such understanding. At the outset, all who attempt to utilize some of the refinements of psychological technique or method in the endeavor to study the soldier and to benefit him must discriminate keenly between fact and fable in psychology. In safeguarding the soldier, we may state here three first conclusions from the psychological view-point:

(1) The soldier must be protected by law and by executives from unnecessary experimentation upon the part of any one, and especially from pseudo-psychologists, cranks and charlatans. It should be recognized that there are many phases even of a scientific psychology that bear not at all upon the pressing economic, medical and personal difficulties encountered in rehabilitation.

(2) Benefits obtainable from judicious use of any phase or method of psychology should be sought or secured promptly. This may be attempted without our losing the perspective of the problem in its manifold economic, medical and personal complications.

(3) Measures promoting mental hygiene are to be ascertained and encouraged. Doubtless in the exposition of such measures some practical cooperation might be secured from The National Committee for Mental Hygiene, New York City.

Conducive to this perspective is a knowledge of the general nature, the divisions, the aims, and the methods of psychology. It might prove feasible to impart in concise simple form to doctors, teachers and counsellors who have not had opportunity for such definite knowledge and who deal officially with returned disabled soldiers, some general established facts dealing with these topics, without any attempt to make of these persons trained psychologists, or to stress unduly the supposed values to be derived from attempts to utilize systematic psychology. For example, psychology, with its working platform of psycho-physical parallelism can be marked off from philosophical or metaphysical speculation. The different types of systematic psychology—philosophical, physiological, genetic, laboratory, and the groups of studies dealing respectively with the animal, the infant, child, adolescent, adult, and senescent mental processes are to be defined in their relative perspectives. It should be made known that there is a rather distinct psychology of the abnormal mind, whether the abnormalities be temporary and borderline—such as the matters of dreams, hallucinations, illusions, fatigue, hypnosis—or pathological, such as the various amentias and dementias. In the field of educational psychology some definite things of practical value are known with regard to the modification of instinctive capacities in emotional and in motor aspects; habit-formation and the learning process; imagination and memory; interest and attention as aspects of consciousness; sensation and perception as elemental factors, and complexes present in all acquisition of knowledge and skill.

Comprehension of the general nature and of the scope of psychiatric work, upon the part of teachers of invalid occupation, trainers in functional reeducation, and perhaps vocational officers and teachers, should contribute to intelligent cooperation and teamwork with psychiatrists in behalf of the soldier. The qualified psychiatrist is a physician who has been specially trained in the study and treatment of mental abnormalities. He is both an expert in the study of abnormal psychology and also in the treatment of the mind. Vocational counsellors profitably might know how to deal best with convalescent cases that may have come through the hands of the psychiatrist. An elementary knowledge of abnormal psychology might aid the vocational officer in detecting more readily the various signs that indicate the necessity of prompt reference of the case to the psychiatrist for detailed study and wise treatment. For example, a representative sub-committee of the Mental Hygiene War Work Committee has recommended to the Surgeon General a simple guide to be used by psychiatrists in order to set forth the different aspects to be looked into in cases with mental symptoms. This outline tabulates the points to be observed in a subject with reference to (1) behavior, attitude, and emotional state; (2) motor condition with reference to general movements and speech; (3) stream of thought —whether clear, relevant, retarded, disconnected, incomprehensible, fragmentary, etc.; (4) content of thought as concerns any pressing anxiety, worry, imperative ideas, obsessions, phobias, delusions, hallucinations, dreams, peculiar ideas, etc.; (5) orientation with reference to time and place; (6) memory and thinking, with regard to recent and to past events, etc.; (7) intellectual level as gauged by quantitative tests as well as by the subjective or "common sense" judgments; (8) the patient's own account of his trouble; (9) his attitude toward the symptoms.

Trainers in functional reeducation, and vocational officers usually will not have time or inclination to study thoroughly the elements of psychiatry, even were it possible or desirable. It would seem possible, however, to acquaint them with a few essential facts, including familiarity with such an outline as above in order to facilitate cooperation with psychiatrists and physicians. In the various anxiety neuroses, and especially in the various conversion hysterias where a fixed idea has been transferred by the disabled soldier into physical symptoms (such as tremors, monoplegias, paraplegias, hyperaesthesias, stammering, aphonia, mutism, etc.), which it has been shown are often more amenable to reeducation treatment than to medicine, it seems that any such definite knowledge upon the part of the vocational officers in charge concerning these neuroses would be helpful to all concerned.

It would be easy to stress to utterly impractical importance the relative value of such acquired insight upon the part of those having to do with the returned soldier. An attitude of mind, based upon facts, however, might be cultivated in the vocational people, by means of the skillful presentation in conferences and readings of essential facts of abnormal psychology, which might help toward these two desirable results: (1) To be able to recognize more accurately the various factors in the mind of the soldier affecting his rehabilitation, to appreciate better his point of view, and (2) to detect both points of undiscovered capacity as a basis for occupational training, and also to detect serious defects interfering with any proposed vocational training.

Generalizations deduced by a civilian from conferences with small numbers of returned soldiers and from literature are tentative and speculative. The outstanding facts are clear that more than two million of our young men have suddenly found themselves in a world of activity, training and violence, which most of them scarcely dreamed possible during the preceding years of their life. The wrench of change from family, social, agricultural, industrial, business, and professional life, and from the daily routine of comfortable bed, food, recreation, has brought the discipline of automatic obedience in the school of the soldier, exciting travel over dangerous seas, and finally, participation in the indescribable battles of the world war. The majority will return well and sound, eager to take up the pursuits they left off when they became soldiers. Here will come another wrench, a complex effort at still another adaptation to the habituation of peace activities, of thinking for oneself as opposed to the recently acquired war activities and automatic obedience, relinquishment of individual thinking in the military world where thinking is done for the soldiers by the officers, about as regularly as food, clothing, shelter and ammunition are provided.

Such things as the above also have entered into the life of the returned disabled soldier, plus painful memories, a sense of loss, and often the conviction that "I am undone," and forebodings with regard to the future. Probably most of the wounded men are like many of ourselves, who may have felt sick, tired, conscious of having done a duty—but otherwise not very different. Some individuals, however, are full of the hero pose; and there are a few, the Canadian officers say, who were "rotters" or "bad eggs" before they joined the Army, and they will be wards of the Government so long as they can. Officers also have said that ninety-seven per cent "play the game squarely." It is the inevitable three per cent who give trouble and must be detected and understood.

Only individual case studies can reveal to those in contact with returned disabled soldiers the nature of their previous experiences, and consequently their present mental attitude and powers of apperception for anything proposed to the soldier. Skill in eliciting such information without offense, irritation, or injury to the soldier is a desirable trait to be cultivated in counsellors.

BRIEF ACCOUNTS OF EIGHT CANADIAN CASES

1. For example, Major X in Canada is a returned soldier of Scottish descent. He is large, muscular and his face is ruddy with apparent health, although he walks with a cane. Reluctantly he described his experiences during the past three years. Before then he was a civil engineer. Volunteering, he crossed the submarine-infested seas. In the early days mistakes were made, and there were long marches of raw recruits, which might have been avoided. His regiment, still green, was ordered one day to march fifteen useless miles; the next day, twenty-five miles. Each soldier carried a pack and rifle weighing more than sixty pounds. Officers often carried for a while the pack of some discouraged or fainting soldier. Utter weariness, soreness, bleeding feet resulted. There came five successive nights in a shell-swept, rain-soaked trench with hardly any sleep. He was buried under earth from the explosion of giant shells which annihilated two of his friends by his side, and rendered him unconscious. Afterwards he was shot in the knee. Long periods of hospital life followed, and finally he is in Canada again, lame, nerve-shaken, trying hard to adapt himself to office hours and routine. His deceptively healthful appearance hides an almost irresistible restlessness, and his quiet face does not reveal the memories of horrors which live in his mind by day and by night. These things he made plain, but one would not have so judged, except after the delayed recital by himself. The Major works for a living now in a pursuit of peace. His general aims, ideals, are clearly enough defined in his own consciousness; the difficulty is that they for whom and with whom he works may not be enabled to penetrate beneath the surface of his cheerful exterior, and may overestimate his resistance to fatigue and capacity for drudgery, and be insufficiently tolerant of his moods.

2. Private M is a returned sapper, his body gnarled by sciatic rheumatism. For years he had been a miner working hard in regular, quiet routine—a peaceful, humble citizen. Enlisting in 1914 he became a sapper and spent long months and years in digging mines in the damp and mire with the troops overseas, and in incessant danger of being blown up by the mines of the enemy, whose picks and tools often he could hear underground. Now he has returned, and his chief theme is, "We need better means of killing more Germans quickly. Gas and mines are pretty good but we should think up something that will work even better."

He talks and thinks as though his present life were in France. Coal mining only passively interests him; he at times wonders how he will make a living, whether the doctors will cure him; but his real life remains "over there." Definite purposes, aims, or plans for the future do not exist clearly defined for him, and his best potential capacities are not easily analyzed by others.

3. A Canadian sufferer both from amputation and from "shell shock" was designated by the doctor-officers as one suffering from conversion hysteria. That is, certain erroneous perceptions and ideas had been transferred into a physical symptom. In his case there had been a functional alteration or dissociation of consciousness with regard to the organs of respiration and speech, and since leaving the battle field months before, he had been mute. Neurological examinations revealed no serious lesion of brain, nerves, or organs. It was a case for reeducation. Along with other ameliorative measures, placing him with a group of men, who sang daily in a cooperating church near the military hospital, was tried. One day he sang with them and thereafter possessed his voice. Personal attention and explanation of his condition facilitated his recovery.

4. A former Canadian tailor dismissed from the hospital secured employment successively in four or five different shops. He is a massive, excitable man, in peace times perhaps enthusiastic for social and economic reform. His idea, he professes, has been to protect the worker, help in introducing reforms which will make for the conservation of health and happiness, etc. In France, he and particularly his brother became known as "killers." Not boastfully, but with gusto, he describes how his brother dropped a bomb into the midst of a group of assembled enemies in a dugout and how pieces of bodies, contents of stomachs, etc., filled the air. Here possibly is an example of the substitution of a desire to help his fellow men (countrymen) in peace times by thinking and talking, into the desire to do his duty through slaughter hitherto repugnant to him. The animal instinct to kill has been sublimated through motives of patriotism, loyalty and duty. Now that he is returned partly disabled, another transformation in the expression of impulses and ideals under the strict rules of society becomes imperative. Not a man of strong intellect, and irritable through physical shock, he finds it baffling to conform to shop rules and an impatient employer does not tolerate him long.

5. In Montreal a youth, formerly a lineman, had been wounded in the legs, and also gassed. The instructors noted his former occupation and his interest in electricity, and the boy was given a six months' course specially devised at McGill University. He then got a job, and is now in complete charge of the electrical plant in a great Canadian manufacturing company.

6. A disabled soldier who was formerly a bricklayer desired to become a contractor, but could not handle fractions in arithmetic. Under special training he evinced exceptional mathematical ability and now, after several months, he is in trigonometry. A similar case—the man, formerly a teamster, could not read or write. He went to McGill for machine work and became afterwards a foreman at $40.00 per week.

7. One employer engaged a returned soldier who remained practically drunk for four months. He was patient with the man, sent him to a job in the country, which he loves. The man remained and made good, being now a foreman. An officer states that some employers take pains to explain. Others do not, and attempt to exploit the men. "When a civilian superintendent says, 'You are no good,' he gets it in the eye from the soldier who knows that he has made good in places of supreme peril."

8. A soldier, convalescent from a gunshot wound through lungs learned to run a farm tractor at the University of Toronto in less than six weeks and secured a government job in this work. Farm tractor courses here follow both the agricultural and the motor mechanic courses for returned soldiers.

EDUCATIONAL APPLICATIONS OF PSYCHOLOGY IN REHABILITATION WORK

It is recognized, of course, that the work of rehabilitation is supremely complex, and rightly executed demands the harmonious participation of many groups of workers, e. g., surgeons, psychiatrists, dentists, nurses, and hospital assistants; masseurs, hydrotherapists, mechanics engaged in making appliances and in prosthesis; specialists in functional reeducation; trainers in the curative workshop; industrial surveyors; vocational counsellors; commercial, industrial, agricultural and other teachers; employers, employees, corporations and unions; civic organizations including a "War Veterans' Association"; individual philanthropists; the press; the churches; and the man's own family. Our law now makes obligatory an articulation of effort between the Surgeon General's Office, the War Risk Bureau, and the Federal Board for Vocational Education upon which last the Smith-Sears Act of Congress (June 27, 1918) confers large powers and duties in the matter of vocational rehabilitation. It is necessary also that in the social consciousness of the public, practical sympathy and cooperation should be cultivated by well devised means, if overlapping, friction, waste and exploitation are to be minimized. Propaganda and publicity campaigns therefore should be controlled centrally and should be conducted with unusually refined ethical and efficiency aims.

The great public must be taught to know what to expect of the soldier and to appreciate his point of view. We must reeducate not only the disabled man, but also the public. Furthermore, when the boys return home victorious, with changed vision and imperative demands, it will not be so much a matter of *what we will do with the returned soldiers, but rather what they will do with us.*

One of the cases (4) suggests the operation of the principle of sublimation, the importance of recognizing it, and so far as possible of utilizing in practical teaching any established pedagogical principles or practices dealing with the modification of our inherited tendencies (fear, pugnacity, sex, curiosity, constructiveness, etc.). Whether or not we abandon the term instinct, we know that some of these inherited tendencies fully awakened need for control the *substitution* of a social for an antisocial expression; some upon occasion need attempts to *eliminate or suppress* them by removing the stimuli and by associating pain; some of them demand *development* through opportunity or incentive.

Canadian experience confirms the belief that as a rule the soldier's preference and desire must be taken as the cue in giving vocational guidance or direction. Sometimes the interest expressed by the soldier is not that of a life-long habit, but a mere whim or the ephemeral fruit of some suggestions. For example, scores of men unwisely designate *motor mechanics* as the desired occupation. They have been enticed by alleged attractions of the occupation and are ignorant of the present and pending labor supply. Others would go into *toy-making*, not realizing that the occupation, although having pleasant elements, and of possible value for occupational therapy, is unattractive as an industry for soldiers' occupation for three reasons: (1) Some institutional cases making toys will peddle on streets and use money gained for liquor; (2) severity of competition in open market (e. g., with

Japan); (3) it is not well for men to force sales of useless things by using "hero stuff."

The appeal to interest, however, is necessary long before the patient actually selects vocational training or a job. Interest is the keynote both in functional reeducation and also in invalid or bedside occupations. These two topics we shall presently discuss briefly. A curious tendency noted at Ogden near Calgary was that in gardening work. According to the instructor, the men who take most interest in gardening have not done it before. "When they put a seed into the ground and it grows, it seems a miracle to them. I (the gardening instructor) expect it to grow." Assistants or trainers in functional reeducation work, vocational counsellors, vocational teachers, can profitably apply a sane pedagogy of *interest*, appealing to mental and physical habits of healthful, pleasurable activity. They should know the distinctions between work (as directed effort toward a remote end or goal) and labor, toil, drudgery, aimless and painful repetition, whether the goal be recreation, functional reeducation, knowledge, or skill.

At Hart House in Toronto there is in operation a system of mechanical and of psychological devices to promote the functioning of limbs or remnants of limbs. In this matter of functional reeducation which overlaps the activities of occupational therapy, we record the following considerations, after observing the work of the psychologist in charge, Professor Bott of the University of Toronto.

(1) Correct emphasis is laid upon the abandonment of anybody's "system" (e. g., the Zander, the Amar) and upon means adapted to fit the individual case. The laboratory contains scores of useful, simple devices, but Bott informs us that he has thrown more upon the junk heap.

(2) Functional reeducation demands closest cooperation of workers with physicians, and indeed should be done under the supervision of a physician-executive. However, as a subject it overlaps vocational education, e. g., where a man is put to an activity which causes hypermovement of an injured member; and hence the danger should be known to the vocational instructor.

Trained psychologists, versed especially in educational and abnormal psychology, should work as directors of laboratories of functional reeducation. Their assistants or "trainers," selected by the methods in use at Toronto, might profitably know some of the facts and principles which we have indicated in our references to conversion hysterias, abnormal psychology, and psychiatry.

(3) Functional reeducation demands unusual pedagogical skill in the use of the principles of motivation and of suggestion, upon the part of the psychologist, teachers, assistants or trainers. Instead of depending solely upon mechanical movement driven by assistants or motors, the desire and effort of the patient are motivated by the trainers. For example there is the ingeniously managed bowling alley at Toronto for men with stumps of legs which need exercise and hardening before completion of prosthesis. In this case a light temporary artificial leg is attached to the stump, and a simple device makes possible the swinging of the ball by the leg. Interest, rivalry, and the zest of the scored game bring about desired movement of the stump. There are also in Toronto the various metric devices which make visible to the soldier with discouraged or enfeebled will the slightest improvement of their efforts to innervate limbs depending upon vicarious functioning, anastomosis, and the various physiological bases of functional reeducation. Appliances should be kept secondary in the mind of the man, and all harness used must be comfortable and fit so far as practicable. Concentration for a short time is sought rather than aimless repetition. Needless to say, the personnel of the charming group of women "selected from the best families of Toronto" is exceedingly important. Character, tact, intelligence, team work are necessary. The general rule for selection has been threefold: (1) Candidates must enroll for one year. This eliminates at the outset many candidates with merely sentimental interests. (2) Candidates are pledged to four months' training. (3) Candidates are at first appointed only upon probation of two months.

The man confined to bed for many weeks or months must have mental diversion, the most satisfying of which is an occupation or task that requires appropriate and not injurious physical effort. Familiar is the spectacle of the good women teaching the invalids embroidery, raffia, modelling, etc. The results achieved were surprising both in the quantity and quality of work done and also in the serious concentration of mind away from morbid thoughts.

The question arises, could not tasks be devised even *more interesting* to these men and more masculine in nature? The making of small electrical devices, such as bell magnets, the making or assembling of small mechanical devices, perhaps ropesplicing, and more emphasis upon drawing, lettering, etc., might be added to the list of things already found to be of service in this treatment where interest and regulated activity are essential. "The hardest fight I have had in a long time," said a returned veteran at St. Agathe, "is to endure through long silent weeks the quiet of this beautiful place."

Work is not all immediately pleasant, and for instructors to be able to predict something definite about the progress and process in the acquisition of skill and of knowledge is worth while. It has not been found desirable or practicable to plot curves of the changing speed and accuracy from day to day of a patient or student. It is quite worth while, however, for an instructor to know that habit-building in many instances can be charted, as for example in learning to typewrite; that various physical and mental factors affect the rise and fall of the learning curve of an individual engaged in daily attack upon a work of labor or play; and that "plateaus" where no progress is made are likely to occur, calling for urging of the student, or for rest, as the circumstances dictate. Here may be found useful for reference some of the studies of Bryan and Harter, Book, and Thorndike.

Rest is not always demanded where there is a mere feeling of weariness, which may or may not be indicative of exhaustion of muscle and nerve, and of the presence of fatigue poisons. Much nonsense probably has been written about the dangers of fatigue in education, and, since the pioneer but crude work of Mosso and Binet, investigators such as Thorndike, Offner, and Lee have radically modified our views about the nature, causes and consequences of fatigue, which, unless pathological or excessive and incapable of removal after adequate rest, is not dangerous in a learner.

A confirmed tendency in school practice is to depend largely upon formal discipline or doing some painful task in some specific subject in the expectation that therefrom will accrue, or transfer, a general benefit. Acquire accuracy, or speed, or good judgment, or good memory in the doing of one thing and the effect will transfer invariably to all activities in life, it was believed. Upon this plea many a useless and illy-taught course remains in the school programs and it has even affected some of the methods and aims of manual training. It is the exploded doctrine of extreme formal discipline.

In teaching soldiers, this tendency must be safeguarded, especially in the necessary book-work where conventional pedagogues are inducted into the rehabilitation service. The present status of the doctrine of special practice is approximately this: (1) There is a possibilty of considerable transfer effect (through "ideals of method," "generalized experience," "identical elements," etc.) of the results of a special practice. (2) The actual amount of transfer is difficult to ascertain experimentally. (3) Wholesale transfer is usually a grossly false assumption. (4) Much of the present literature is controversial and contradictory. One's attitude toward the whole matter of school ideals, courses of study and methods will be determined largely by his attitude upon formal discipline. If our assumption concerning the significance or practical outcome of the position of educators upon this question be accepted, it seems that vocational teachers might well consider the results of the studies of Thorndike, Colvin, and Judd upon this central topic of educational science.

THE QUESTION OF MENTAL TESTS

Mental tests as used in late years by Binet, Goddard, Knox, Franz, Bingham, Terman, Pinter, Whipple, and Yerkes are to be distinguished from formal experiments of the psychological laboratory. In the first place they do not call for difficult introspection; in the second place, most of them are intended to gauge or estimate quantitatively "general intelligence," or "mental capacity as distinguished from knowledge or information," or "mental maturity," or to probe specific traits. It is well known that they are being used upon recruits in the United States Army as an aid to classification and promotion, and that certain large corporations are conducting a five-year experiment in order to derive helpful means in the selection of salesmen and to lessen the turnover of labor. For many years mental tests have been used in the study of exceptional children, in good practice by skilled testers working only in connection with physicians, teachers and social investigators.

Attempts to build a system of vocational guidance solely upon the basis of mental tests have failed to date. Hollingworth has shown that similar attempts, as with palmistry, fortune telling, phrenology, etc., have long been a persistent pursuit. Sound vocational guidance is inextricably interwoven with the problems of: (1) individual choice; (2) training for occupation; (3) getting the right job; (4) promotion; (5) industrial surveys, etc. It cannot depend solely upon mental tests, although these in skilled hands may be useful and essential in studying the disabled individual with reference to vocation. With regard to possible desirable applications of mental tests in the matter of rehabilitation of returned disabled soldiers, we may formulate these tentative observations:

(1) In Canada dependence is placed upon "common sense" evaluations of the general intelligence of soldiers, made by the vocational officers. It is to be noted, however, that: (a) Estimates of a given individual's intelligence made by different persons will of course vary. Such guesses are subjective. (b) Even in this crude work the officer inevitably uses tests, the crude trials and criteria of his own.

(2) In the United States, we might continue the Canadian method of securing the estimates of the vocational officers, but these estimates should parallel or follow an expeditious and quantitative testing of the man before discharge from the Army. It is to be noted that thousands of our troops already have left records on file of such quantitative evaluations, before going overseas. Doubtless the Federal Board for Vocational Education now entrusted with heavy responsibilities under both the Smith-Hughes and the Smith-Sears Acts of Congress, with the characteristic energy and sagacity already displayed will use wisely any available records or devices to help to gauge the intelligence and capacity of the men to be trained and placed vocationally.

(3) All quantitative mental testing work should be done preferably by trained psychologists, or by psychiatrists whose experience includes industrial contacts. It cannot be done well by doctors who have had merely the general training of the average medical school, or by the average teacher. Uniformly, such work will be done in the hospital, about the time of discharge. In the vocational education work, after the man is discharged, a few psychologists with industrial experience or contacts might be employed for retesting and for the analysis of difficult cases. An obstacle will be to find qualified persons for the work. The writer candidly advises that great discretion should be exercised at this point, and if enough scientifically trained men with industrial contacts or experience cannot be found for this work, we should rely upon a modification of the simple, though somewhat crude, method of the Canadians in the use of their *Form 106, question 6*, and in connection with the confidential directions for its use in estimating "general intelligence." The psychological testing work holds valuable potentialities, but it is secondary in

importance to the problems of health, education and industrial welfare confronting the returned soldier.

SUMMARY CONCERNING REHABILITATION

Studies of the remarkable development of the Canadian system now under the Department of Soldiers' Civil Reestablishment and a survey of European systems indicate these points for further consideration, if not immediate application, in the United States:

1. *The chief problems.* The perpetuation of democratic principles, questions of organization, aims, finance, control, industrial surveys, courses of study and equipment, coordination with existing schools, placement, public education, and the matter of physical and mental restoration or conservation—these are the urgent problems of rehabilitation.

2. *The soldier, the center of effort.* The soldier must remain the center of effort; and no exploitations of anything should be permitted.

3. *Accumulative, individual records.* To understand the soldier we need a simple and effective record system that will be *accumulative* and that will *follow him* from enlistment, overseas and back, to placement in industry. The Canadian system is ingenious and rather complete, but there have been avoidable delays, and it is not quite clear that for the use of the vocational officers the records are sufficiently accumulative, or if so, that they are convenient for quick access.

4. *Abnormal psychology.* Where there are abnormalities in mental status to be studied, it is work for the psychiatrists. Where hypnosis is indicated for treatment it should be brought on only by a physician, or by a psychologist cooperating with the doctor.

In functional reeducation psychologists who are trained in educational psychology and with insight into the worth of Amar and Bott can be of service in cooperating with surgeons. Perhaps it is feasible to give prospective "trainers" or assistants an elementary knowledge of relevant facts in abnormal psychology.

5. *Educational psychology.* The field of experimental results in educational psychology should be gleaned for facts that bear upon the matters of instinct, habit-building, interest, work, fatigue, the learning process. Teachers should be employed who know these things and do not confuse scientific psychology with metaphysics, phrenology, thought transference, mesmerism, etc. It might prove worth while to give teachers of occupational therapy, and counsellors, who lack satisfactory knowledge, a short course of

such training in order to help them to understand the mental attitude of the soldier, the functions of the psychiatrist, and to apply during instructions only methods of value.

6. *Mental tests.* Quantitative testing belongs to the spheres of the psychiatrist and of the specially trained psychologist. Persons who combine technically psychological training with some industrial insight are desirable for this work, most of which will lie in the hospitals. Vocational counsellors, teachers, etc., ordinarily should not attempt to use these technical means of gauging mental capacities. Some of the psychological tests appear to be so simple that their use appears easy, but like the simple knife of the surgeon, quantitative tests require special skill in use and in interpretation of results. Perhaps the records already made in Army cantonments of the United States may be found of some use.

7. *Intelligent cooperation.* Essential to the success of rehabilitation is thorough understanding of the necessity, aims and methods of the undertaking upon the part of the public and of the soldiers. It may be necessary to organize a propaganda of information for the soldiers—for all soldiers here and overseas. They, and citizens at home, statesmen, educators, doctors, employers, employees, may advisedly cooperate heartily in the great work of rehabilitation, which doubtless will include in the future the victims of industry as well as the victims of war.

8. *Literature of rehabilitation.* The most complete printed bibliography of the rapidly increasing literature upon the subject of rehabilitation is contained in Bulletin 15 of the Federal Board for Vocational Education, Washington, D. C., published in May, 1918. It is entitled *The Evolution of National Systems of Vocational Reeducation for Disabled Soldiers and Sailors.* It contains records of the work done in France, Belgium, Great Britain, Italy, Canada, Australia, New Zealand, India, South Africa, Germany and Austria-Hungary. The monograph is quite a mine of information concerning the principles of rehabilitation. Practices with regard to organization, medical care, prosthesis for cripples, occupational therapy, insurance, pensions, and concerning occupational training, industrial surveys, vocational advisement, placement, etc., are set forth by the writer, Douglas C. McMurtrie. Doubtless the study of this bulletin will facilitate unified intelligent effort upon the part of the Federal Board for Vocational Education, other agencies of our Government, and the great American public in behalf of the men who come back from "over there."

PERSONALITY STUDIES AND THE PERSONAL EQUATION OF THE AVIATOR

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THE study of the personality of the aviator has the following three definite objects in view:

(1) To detect the presence of nervous and mental diseases which will render the aviator temporarily or permanently unfit for service.

(2) To form a definite idea as to what extent the aviator will stand the pressure of life at the front.

(3) To determine, and as far as possible to compensate for, the existence of any latent tendencies, which under the strain of actual warfare would become so accentuated as to make the aviator either inefficient, or to increase his danger of nervous and mental collapse.

The plan for collecting the data for personality studies has been adopted as the result of practical experience gained in making several hundred examinations of aviators, and after repeated conferences either with American officers who have seen service at the front, or with representatives of our Allies.

Any history to be of value to military men must be brief and comprehensive, and for this reason the effort has been made to limit the data recorded to a single typewritten page. The "Personality Summary" of a few lines further facilitates the practical application of the information obtained. The records are primarily intended to serve the military purpose of estimating the nervous potential of the aviator, and are in no sense post-war prognoses.

The sources of information for these histories are as follows: (1) the aviator himself, (2) his military record, (3) Flight Commander, (4) Flight Surgeon, (5) Physical Director, and (6) the notes of the neuropsychiatrist.

Intelligent and sympathetic cooperation between all the different officers is essential in order to secure a reliable and complete record. The officer making the personality study should put himself *en rapport* with the aviator and avoid doing or saying anything suggestive of fault finding, or of casting any doubt upon the genuinely sympathetic interest of the examiner in assisting each aviator to correctly appraise his own limitations and capacity. The value of these brief studies in reducing the number of casualties due to preventable causes and in increasing efficiency has already been clearly demonstrated.

The name, residence, rank and organization of the aviator and the date of his examination are recorded at the top of the blank. The data obtained in the examination are grouped under four heads:

(1) *Aviation*, containing the essential facts relating to the aviator's training and service. Reference is made to his reasons for choosing this branch of the service, to the causes of "repeats" in the Ground School, to the occurrence of accidents, and to the total number of hours flying, maximum altitude attained and the time spent at this altitude.

(2) Under *Personal History*, special reference is made to the attitude of the members of the immediate family towards aviation, since any dissatisfaction or active opposition on their part may be disastrous to the aviator, either by immediately precipitating an accident or laying the foundation for states of anxiety and apprehension. The occurrence of diseases and injuries having any direct bearing upon his ability to fly are recorded, as well as the character of the interest in sports, athletic training, personal habits, sleep, dreams, somnambulism, and feelings of satisfaction and accomplishment.

(3) The *Physical Examination* begins with a reference to the height and weight, as there seems to be a definite relation between these two factors in determining the best type for aviation. Special attention is given to the examination of the pupils, noting particularly whether there is a secondary dilatation of the pupil following the primary contraction due to the incidence of light, the condition of the deep and superficial reflexes, the psychomotor tension measured by the ability to relax the muscles of the extremities, the presence of tics and tremors, the dermographic reaction, indicating any tendency towards diffusion and blotching, and recording any evidence in the facial expression or behavior of fatigue, stress or states of anxiety.

(4) *Personality Study* includes a summary of the chief qualities of temperament and character, laying stress upon the personal traits which should be of value in aviation.

Experience has shown that aviators having the following symptom-complex are inefficient and incapable of exercising good judgment in facing critical situations: (1) marked and prolonged secondary dilatation of the pupils, (2) very active deep reflexes, (3) recently developed tics, (4) tremors of the tongue and fingers, (5) imperfect muscular relaxation and (6) a diffuse and blotchy dermographia.

The three main objects of the personality study as already stated should be closely followed when analyzing the temperament and character of the aviator. In recording impressions of the personality the examiner is not expected to refer to all the points mentioned on the blank but he should present the outstanding characteristics of the personality in a brief accurate summary.

Examinations are conducted with the following outline as a guide:

MEDICAL RESEARCH LABORATORY

HAZELHURST FIELD, MINEOLA, L. I., N. Y.

Name Age S.M.W. Nationality (F. & M. Grandparents) Date

Residence Rank Organization

I. FAMILY HISTORY

II. PERSONAL HISTORY

Diseases (childhood and adult life), childhood fears, stammering

Injuries, operations

Education: school and college, any difficulties, any failures, reason for stopping

Athletic training: in school and after, indoor and outdoor (have athletic tendencies been continued after school life)

Evidences of manual dexterity as in billiards, tennis, etc.

Occupation in civil life (sedentary or active), success

Favorite amusement, method of relaxation

Tobacco, alcohol (has there been any special desire for stimulants since flying). Eating, sleep and dreams

Attitude of family (if married, has it affected your flying)

III. AVIATION RECORD

Enlistment: date, place, sworn in, assigned to (branch of service). Active service: entrance or transfer to Air Service. Aviation school work, repeats. Aviation: active service, date of commission, dates and places of training, hours of flying, maximum altitude, duration, accidents, cause and effect. Reason for selecting aviation, relative interest in flying and in mechanics. Reaction toward your first, second and third solo flights

IV. PHYSICAL EXAMINATION
    Height, weight (gain or loss), general build, personal appearance
    Pupils, character, reactions, character of secondary dilatation
    Knee jerks
    Psychomotor tension (normal or increased)
    Tic. Tremor (hands and tongue). Draw parallel lines and write slowly
    Dermographia: (before and after rebreathing). Describe fully the phenomena, including the time reactions
    Condition of peripheral circulation; moist, cold hands; pale face; soft and flabby muscles
V. PERSONALITY STUDY
    A. Temperament
        Cheerful or depressed, stable or unstable, self-reliant or submissive, aggressive or pacific, modest or vain, frank or withholding, tendency to unburden, fond of people or likes to be alone, satisfied with or hypercritical of conditions, punctilious or careless, serious or frivolous, cooperation, sportsmanship, high tension, pleasure in work, irritable
    B. Volitional
        Energetic or sluggish, quick or slow, impulsive or deliberate, controlled or restless
    C. Intelligence
        Precise or vague, penetrating or superficial, sharp or dull, alert, hesitant or deliberate, resourceful or without initiative, trained or untrained
REMARKS
RATING

The information obtained from the personality studies has a direct practical bearing in assisting the aviator to maintain or increase his efficiency, to keep his nerve and morale and to make a rational effort to direct all of his nerve and brain power without useless dissipation to the task of winning the war.

In making these psychoanalytic examinations the special significance of certain reactions should be kept clearly in mind. The importance of the conscious reactions should not be overestimated, and their intimate dependence upon reactions lying far below the level of awareness (in the subconscious) should be remembered. The sudden likes and dislikes we develop for persons or events concerning which we know little or nothing is an example of the influence of the subconscious.

A chain of ideas, the result of an emotional disturbance with roots extending deep down into the subconscious field, possessing an overvaluation and unexpected driving force, forms what is called a complex. An aviator who becomes obsessed with the notion that it is no longer necessary for him to observe any of the ordinary precautions taken to preserve life assumes this attitude as the result of a mental complex, and the difficulty in substituting new ideas for this complex depends on its isolation from most of the other mental processes. Complexes are quickly formed if definite decisions are not reached and a line of action decided upon when facing any dilemma or critical situation. The efficiency and courage of the aviator depend to a very large extent upon his readiness and willingness to get square with embarrassing or unpleasant situations, avoiding any inclination to dodge an issue with all of its consequences. In the majority of cases it is not difficult to form an impression as to whether the aviator is accustomed to taking life as it is, or has formed the habit of substituting imaginary conditions for reality, of going round a dilemma, and then attempting to obliterate the memory of this lack of decision or to substitute for gnawing recollections of vascillation a stream of wish-directed-thoughts. The embarrassment of the slacker and his personal conflicts precipitated in the attempt to justify his position to himself and his friends are a familiar example.

Unpleasant memories may be temporarily suppressed, but when they are actually forced out of consciousness and are definitely repressed they become insidious and disorganizing in their effect upon the entire personality. An important distinction should be observed between an event which, as Rivers says, is only temporarily inaccessible to memory, and one removed from memory by a definite voluntary act of repression. Mere inaccessibility to memory and the kind of forgetting due to active repression are two distinct processes which should be very carefully distinguished, as the former condition in contrast to the latter does not tend to split up or disorganize the entire personality. States of doubt, apprehension, anxiety, morbid fears, the tendency to impulsive acts, and the substitution of wishful thinking for logical and rational thought-processes often are referable to acts of repression.

Under the stress and strain of life at the front many personal idiosyncrasies are magnified until what may have been once only amusing peculiarities quickly change into reactions that are incompatible with prompt and efficient action and tend to undermine the morale of groups of aviators.

The occurrence of dreams with increasing frequency, especially if associated with heightened emotional tension and irritability during the waking hours, and either restless sleep or sleeplessness should be recognized as danger signals. Dreams are often of an occupation type and generally include some unpleasant dangerous incident in the aviator's daily life. Thus an aviator who has been flying almost continually for several months but without accidents is fatigued and may first show signs of serious staleness in dreaming of tail spins, side slips, crashes, engine trouble, etc. The oftener such dreams are repeated the more serious is the condition, as the dreamer soon develops first an apprehension then an anxiety and finally a morbid fear. Dreams of this character indicate the need of rest, and the failure to appreciate the significance of these danger signals will result in a mishap.

It is very important that an aviator during the hours immediately following some exciting or disturbing incident in his life should not be unnecessarily exposed to the demoralizing influences of suggestion. The "period of meditation," as Charcot called it, is the incubation time for hysterical disorders. After a crash, fright or any incident causing severe mental or physical strain, the aviator should be in an environment where he receives intelligent care and sympathy, but is neither coddled nor neglected.

NOTES AND COMMENTS

Illinois

The Illinois Department of Public Welfare has established schools for the training of nurses, social workers and occupational therapists, in response to the demand for persons with technical training along these lines.

TRAINING SCHOOL OF PSYCHIATRIC NURSING

The first one to be in operation is the Training School of Psychiatric Nursing. This course is designed especially to prepare women to care for patients suffering from mental and nervous disease. The course of instruction covers a period of three years. All graduates will be eligible for positions as psychiatric nurses in the state hospitals of Illinois. They will also be qualified to take examinations for the Illinois Diploma of Registered Nurse, and for service with the Army, Navy and Red Cross.

Practical teaching will be given in the Chicago State Hospital in wards selected to give training in all phases of mental nursing. Instruction in surgical, orthopedic, obstetrical and children's nursing will be provided through affiliation with other training schools for nurses in Chicago. The probationary period, first and third years will be spent at a state hospital, while the second year of the course will be given in a hospital for physical diseases.

The curriculum includes anatomy and physiology, bacteriology, personal hygiene, household economics, dental hygiene, chemistry, drugs and solutions, materia medica, dietetics and cooking, ethics, general nursing (theory, practice and demonstration), psychology, medical diseases, surgical diseases, infectious diseases, occupations, amusements, orthopedics, obstetrics, pediatrics, administration, psychiatry (with clinics), mental nursing (theory and practice), hydrotherapy, massage, occupational therapy, social service and mental hygiene.

Regular courses of instruction are planned to start at the beginning of October and January, but requests for enrolment will be considered at any time. Application forms for admission may be secured by addressing the Superintendent of the Training School of Psychiatric Nursing, Chicago State Hospital, Dunning, Illinois.

TRAINING SCHOOL FOR OCCUPATIONAL THERAPISTS

This course will be given in cooperation with the Henry F. Favill School of Occupations, Illinois Society for Mental Hygiene, under the direction of Mrs. Eleanor C. Slagle, General Superintendent of Occupational Therapy.

The purpose of this training school is to give instruction in habit training and occupations with special reference to the prevention and treatment of mental and nervous disorders. Details in regard to this course have not as yet been completed.

TRAINING SCHOOL FOR SOCIAL WORKERS

This school, in which special training will be given in psychiatric work, is designed as a war emergency measure, for which there is great need, also to provide trained workers for permanent positions in the service of the state.

The course of instruction, which begins January 6, 1919, will cover a period of eight months, two to be spent in intensive study and demonstration and six in practical field work under supervision in connection with the various state institutions.

The work of the first two months has been divided into two parts. One of these, which continues throughout the course, provides for instruction in sociology, psychology, psychiatry, delinquency and social service methods. The other concerns practical demonstrations, readings and discussions, the subjects being divided roughly into weeks as follows: history taking and records, mental testing, occupational therapy, the care of children, modern court methods, after care of mental cases, probation and parole in correctional cases, after care in military cases. Special instruction will also be given in public health, hygiene, recreation and first aid in emergencies.

Examinations will be held in the various subjects taught and credits given for case work in the field. A diploma will be granted upon the successful conclusion of the course, which will render the graduate eligible for employment in the state social service work.

In addition to officers in the Department of Public Welfare, lecturers and instructors have been secured by the cooperation of the following universities and public or private agencies: American Red Cross, Chicago Chapter; Central Free Dispensary; Chicago School of Civics and Philanthropy; Chicago Federation of Settlements; Cook County Hospital, Social Service Department; Federated Jewish Charities; Illinois Children's Home and Aid Society; Illinois Department of Public Health; Illinois Federation of Women's Clubs; Illinois Society for Mental Hygiene; Immigrants' Protective League; Juvenile, Municipal and Criminal Courts of Chicago and Cook County; Loyola University; Northwestern University; South Parks Association; State Council of Defense; United Charities of Chicago; United States Department of Labor; University of Chicago; University of Illinois; Visiting Nurse Association of Chicago; and Volunteer Prison League.

Requests for further information and application blanks may be made to the Superintendent of Social Service, Juvenile Psychopathic Institute, 1812 West Polk Street, Chicago.

Massachusetts

Chapter 64 of the Resolves of 1918 creates a commission to investigate the methods of treating defective delinquents, feebleminded persons, persons suffering from excessive use of alcohol or drugs, criminals and misdemeanants. This commission is to consist of the Director of the Bureau of Prisons, the Chairman of the Advisory Prison Board, the Chairman of the Commission on Mental Diseases, the Secretary of the State Board of Charity, the Superintendent of the Massachusetts School for the Feebleminded and the Supervisor of Administration. This commission is to look into the need for additional accommodations for the care of the classes mentioned. The present methods of custody and treatment of women offenders who are feebleminded or diseased, and other methods which in its opinion will better protect public health and promote public welfare, are to be considered by the commission.

An appropriation of $7,000 was made by the 1918 legislature for the expenses of an investigation of the nature, causes, results and treatment of mental diseases and defects. This investigation is to be under the direction of the Massachusetts Commission on Mental Diseases.

New York

The New York Prison Commission is conducting an investigation bearing upon the needs for extending psychiatric facilities to the penal institutions of the state. The Commission is making this investigation with the cooperation of the State Commission for the Feebleminded and the National Committee for Mental Hygiene, which is supplying an expert psychiatrist as adviser. The purpose of the investigation is to outline legislation for taking care of those sufferers from mental defect or mental disease amongst the criminal population sentenced to the state prisons. The preventive aspects of delinquency will be considered by recommending the creation of clinical facilities in the courts as well as in the prisons of the state. A report will be prepared to be presented to the legislature, embodying the following points: (1) extent of the crime problem in New York, (2) existing provisions for administering it, (3) suggestions as to its solution and (4) definite recommendations for the immediate future.

It is not intended to ask the state to appropriate large funds at the present time in order to make any very radical changes, but effort will be directed towards the intelligent use of existing agencies and institutions by means of reclassification and redistribution through the establishment of a clearing house or reception prison, as has for a long time been advocated by various persons interested in the problem of delinquency.

Hawaii

The Governor of Hawaii has recently appointed a commission to investigate feeblemindedness in the territory. The commission was created by a special session of the legislature after the need was pointed out by the territorial grand jury and a judge of the criminal, divorce and juvenile divisions of the circuit court. The commission is to investigate cases of feeblemindedness in the territory with a view to providing means for caring for them, especially young girls and boys who are found to be feebleminded.

A resolution was recently introduced in the United States Senate which would provide for the appointment of a commission of three to examine into the subject of narcotics and habit-forming drugs. This resolution carries an appropriation of $50,000 for the expenses of the commission.

Psychopathic Institute for Winnipeg

The General Finance Committee for Winnipeg recently held a meeting to award a contract for the construction of the new psychopathic institute, to be established in Winnipeg, which is to be used for the care and treatment of soldiers from Manitoba, who are suffering from psychopathic conditions. The provincial government voted $50,000 two years ago for the establishment of this institution, but a sum exceeding this amount will be required. This excess will be provided for by a special vote at the next session of the Provincial legislature.

Venereal Disease Control

The *American Journal of Public Health* announces that in twenty-four states definite arrangements have been made to cooperate with the United States Public Health Service in a program to control venereal diseases, and that twelve other states have expressed a wish for such cooperation. In practically all of the twenty-four states regulations have been passed which provide ample authority for dealing with the problem according to the plan approved by the Surgeons General of the Army, Navy, and Public Health Service. The campaign in these states follows four principal channels:

(1) Educational: Acquainting the public with the nature of the diseases and the objects desired to be accomplished.

(2) Law enforcement: Securing cooperation of the physicians in reporting cases, and of the police in apprehending prostitutes, vagrants, and such other persons as can be reasonably suspected of having venereal disease in communicable stages.

(3) Propaganda to secure local funds for providing detention homes and hospital facilities for isolation and treatment of venereal disease carriers who by their habits are a menace to the public health.

(4) Establishment of increased facilities for early diagnosis and treatment.

In the Family

" 'The skeleton in the cupboard' is having rather a bad time, first because in these days of apartments and flats no cupboards can be spared, secondly, families are now less afraid of him, and, aided by health lecturers, psychologists and 'popular science,' dispensed in mild doses in the Sunday papers, they rather enjoy dragging him out and discussing that particular form of crime or disease which led to a tombless life. They even take melancholy pride in the number of members of the family who have followed in his footsteps, these not being able to avoid it, because 'it is in the family,' a sentiment which recalls the old game of 'My Aunt Margaret is dead. What did she die of? Shaking her head as I do.' The player would shake and continue shaking while telling her neighbor, who would pass on question and answer until all the party were shaking, the announcement being repeated with variations as to symptoms until all the children were in a pseudo-choreic condition.

"These 'imitation' games often appear as stern reality when, as in the case of an epileptic being in the family, the brothers and sisters approaching to or at puberty will often develop an inclination to pseudo-attacks of faintness and fall to the ground, or will unconsciously fix an imitation into a habit when there is a case of marked chorea among them.

"But, notwithstanding all the calm alleviating light which has been thrown on heredity, it is still an obsession with many that they themselves or some member of the family must be heritor of the ancestral crime or disease, and this belief, recited constantly when young or delicate people are around, has accelerated the departure from this world of many a nervous or frail person. No use fighting; it is 'in our family.'

"Their fears seem justified when the doctor consulted makes a 'case history' and asks if there are any familial diseases, or of what their near relatives died. 'Ah, he, too, thinks I have inherited consumption (insanity, gout, cancer, etc.),' and they forthwith resign themselves to semi-invalidism and often selfishly lose any sort of reluctance with regard to constantly draining the sympathy and purse of the family. We recall an Irish family who jokingly said but firmly believed that 'all our family go to the bad (physically or morally) when they are forty,' and if, toward this age, adverse fortune or ill health came, they simply made no effort to fight but resigned themselves to the seemingly unavoidable, with the natural consequence that through dissipation and recklessness, some did surely die, and the relations were melancholy but triumphant. This species of mind argues from minorities, and it is, happily, forced to take some comfort from the knowledge that thousands of boys, coddled and screened because they were delicate, even their doctor advising against anything strenuous, have become fine muscular young giants during the hardships of war. At any rate, more wholesome views are taken today of familial disease and frailty. To have a relation 'put away' or one operated on for cancer is no longer spoken of in awed whispers as something disgraceful, but as a disease to be fought against, so it is to be hoped that in time the grisly hand of Death will be loosened from the robe of the living and a determined, rational, cheerful fight be kept up against the skeleton in the cupboard."—Editorial, *New York Medical Journal*, August 10, 1918.

INDUSTRIAL FATIGUE

"Real efficiency, not the efficiency that comes from destroying one's competitors or undermining them by intrigue, but the wholesome kind of efficiency that is signalized by a maximal continuous output of high quality, is today demanded by the world more than ever before. Many factors influence human working powers, and the scientific analysis and evolution of these factors can hardly be said to have gone beyond the initial stage. It is even now clearly seen, however, that one very important handicap to the attainment of efficiency is the production of excessive fatigue by excessive work. A paper recently prepared by the Divisional Committee on Industrial Fatigue for the use of manufacturers in the present emergency embodies a series of clear statements of the ways in which industrial fatigue interferes with maximal output and of the best known methods for reducing fatigue.

"Many administrators, writers and other sedentary workers have long since learned for themselves the lesson that the overtaxed mind, the jaded imagination, cannot be driven advantageously beyond a certain point. Mental fatigue is one of the well-recognized barriers to mental efficiency. Long hours do not connote a satisfactory productive activity of the mind; often they connote the reverse. It may, however, come as a surprise to some manufacturers to learn that when industrial output can be measured, a lessening of the hours of labor is sometimes actually accompanied by an increased production. In the instance of an English munition factory cited in the paper referred to, when the average weekly hours of men sizing fuse bodies were reduced from 58.2 to 51.2, the total output was increased 21 per cent. A certain granite-cutting company found that 'the same man under identically the same conditions accomplished more of the same kind of work when he was working nine hours than he did when he was working ten hours. And again when the hours were reduced to eight hours, the same man accomplished still more in an eight-hour day than he did in a nine-hour day, or a considerable amount more than he did when the day was ten hours long.'

"Among the ways of reducing fatigue suggested in the report are the introduction of recess periods, the proper supervision of ventilation and other sanitary conditions within factories, the avoidance, just as far as possible, of overtime and Sunday work, the adjustment of speed to individual capacity, and the introduction of occasional variety into the work of those engaged in the often monotonous machine processes. The results achieved by the application of such methods have frequently been surprisingly satisfactory, and encourage their extension and trial on a wide scale. As a practical hint the committee is careful to point out the necessity of using objective methods of measuring and detecting fatigue. Not every man who thinks he is fatigued is really so. It does not follow that because many workers accomplish more in eight hours than in ten, they would accomplish more in two hours than in eight. The committee also touches on the psychologic factors involved, and more might well have been said on this point. The good spirit of the worker, his friendly attitude toward his employer, is a particularly important stimulus to output. The old copybook adage that willing hands make light work is as true as it ever was. The immediate and marvelous success of the reorganized Shipping Board testifies to the value of good will as a factor in industry. Fatigue is somehow lessened or its coming retarded wherever work is carried on in a spirit of eager cooperation and enthusiasm.

"It may be remarked, finally, that possibly military as well as manufacturing establishments may find some suggestions of value in the consideration of the factors and significance of industrial fatigue. Apparent speeding up by long hours and excessive muscular work may in some cases lead to a delay in reaching the end desired. The admirable results already attained in our training camps by recognition of many of these factors of fatigue are well known. The new recruit is not inured to fatigue work rapidly by becoming fatigued too much or too frequently."—Editorial, the *Journal of the American Medical Association*, September 14, 1918.

INSTRUCTION IN WAR NEUROSES AT MAUDSLEY HOSPITAL

A course of instruction in war neuroses, open to all medical officers of the British and American services and to civilian physicians, is being given under the sanction of the War Office at the Maudsley Neurological Clearing Hospital, Denmark Hill, London. Applications for admissions are to be made to Brevet Lieut.-Col. F. W. Mott, M.D., F.R.S. The course consists of instruction and practice in diagnosis and treatment, systematic lectures and demonstrations. The following topics outline in a general way the nature of the course: (1) The anatomy, physiology and pathology of the nervous and muscular systems applied to the diagnosis, prognosis and treatment of war neuroses, (2) The physiologic and pathologic conditions underlying shock—emotional, commotional and surgical, (3) The methods of examining cases of functional nervous disorders (hysteria, neurasthenia and psychoses) and the determination of fitness for military service, (4) The methods of differential diagnosis of organic and functional disease and the combined condition, (5) The diagnosis of conscious simulation (malingering), unconscious simulation and exaggeration, (6) The general principles of treatment of functional diseases of the nervous system, (7) General aspect of the surgical side of neuromuscular disabilities and (8) General principles of psychology as applied to war neuroses.

THE NEUROPSYCHIATRIC SERVICE IN THE ITALIAN ARMY

Dr. Sante Naccarati in an article on the medical organization of the Italian Army, in the *Journal of the American Medical Association*, November 2, describes as follows the neuropsychiatric service:

"The Neuropsychiatric Service is one of the best services in the Italian army. Italy, having entered the world war nine months after the other allies, had time enough to study all the problems connected with the medical organization and was in a position to avail herself of the experiences of the other nations. While in France the Neuropsychiatric Service as a special unit was organized a long time after the war broke out, in Italy it started with the war. Moreover, Italy led the other nations in creating the so-called advanced neuropsychiatric sections, which are first line hospitals or sections of field hospitals, where the neuropsychiatric patients are first taken for diagnosis, distribution and eventual treatment. These advanced neuropsychiatric sections of the armies originated in Italy in September, 1915, three and one half months after Italy declared war, after a short experimental period. In France, where the Neuropsychiatric Service has now reached perfection, it was not until April, 1916, that a committee composed of Drs. Chaslin, Colin and Truelle, chosen by the medicopsychologic society of Paris, proposed and obtained the creation of similar sanitary sections.

"In order to give an idea of the whole Neuropsychiatric Service of the Italian army, distinction must be made between the neuropsychiatric service in the zones of the armies and the psychiatric and neurologic services outside the war zone.

"The entire Neuropsychiatric Service is under the supervision of Dr. Tamburini, professor of psychiatry at the University of Rome, who is the consulting psychiatrist general to the war office.

1. "*The Neuropsychiatric Units in the Zones of the Armies.* These are mixed formations composed of:

(a) "Advanced Neuropsychiatric Sections: These, as stated, are located in the first lines, either as wards of field hospitals or as separate hospitals. They have a limited number of beds, ranging from ten to 150. The neuropsychiatric patients are sent there either directly from the firing lines or from other field hospitals. A first examination separates the mild cases from the serious ones. The former patients are kept there and treated for a short period of time, after which most of them recover and are sent back to their regiments, save a few who require further observation or treatment, and these are sent to the neuropsychiatric center of the respective army. The latter are sent directly to the nearer neuropsychiatric center, after all the important anamnestic data, the clinical history and a provisional diagnosis have been obtained.

(b) "Neuropsychiatric Centers of the Armies: These are units, one for each army, located in the rear, usually in the same town where the director of the Army Medical Service of the army resides. They occupy large modern hospitals fitted with apparatus for diagnosis and physical therapy, where patients sent from the advanced neuropsychiatric section are received and submitted to a more accurate and rigorous examination. Here those functional cases, emotive, confused, etc., which, if transferred directly to reserve hospitals outside the war zone, as it was customary at the beginning, would become chronic, are treated until the patients are fit for service again. Those suspected of malingering are kept under strict observation until they are exposed or found mentally affected, in which case they are either recommended to a board of survey for medicolegal decisions, or are sent with the other serious cases to the reserve psychopathic hospitals outside the war zone. This occurs only when all means of treatment have failed and when the diagnosis of psychoses or organic neurologic lesion requiring long treatment is made. Recently, after the creation of the distribution center of Reggio Emilia, it was decided that all such cases should be directed to this center, for whatever decision.

"The whole neuropsychiatric service of the zones of the armies is under the direction of neurologists and psychiatrists (one for each army) of unquestionable merit, chosen from among the best in the service, who have been connected for many years with neuropsychiatric clinics of the universities. A staff of trained neurologists and psychiatrists is attached to each neuropsychiatric center.

2. "*The Neuropsychiatric Service Outside the War Zone.* While the neuropsychiatric units at the front are mixed formations, a condition dictated by emergency and practical reasons rather than by scientific ones, the units outside the war zone are either neurologic or psychiatric. These include reserve military hospitals, university clinics and asylums, and constitute (a) the psychiatric sections and (b) the neurologic centers.

(a) "The Psychiatric Service: This deals with two kinds of patients: (1) psychopaths requiring further clinical observation or treatment or medicolegal decisions, and (2) psychopaths that have to be interned in asylums or state hospitals. For practical purposes it has been decided to send the psychopathic soldiers to the hospitals nearest their birth places. This disposition facilitates a great deal the task of the psychiatrists in collecting all the necessary anamnestic data directly from the families of the patients, and enables the patients to live in their own environment, climatic and social. Those under observation remain there for a period of time not less than three months before they are discharged from the army and sent to state hospitals, of which there is one in each of the sixty-nine provinces in Italy. The psychiatric service outside the war zone is done in part by medical officers and in part by civilian psychiatrists, the chiefs of university clinics and asylums, who on account of their old age cannot be in active service. Towns where psychiatric sections are located are: Padua, Verona, Turin, Genoa, Parma, Alessandria, Reggio Emilia, Bologna, Ancona, Imola, Florence, Arezzo, Lucca, Siena, Rome, Aquila, Bari, Catanzaro, Naples and Catania.

"A distribution center for all the psychopaths from the war zone has been recently located at Reggio Emilia. This center is composed of five sections having a total capacity of 1,600 beds, of which 150 are for officers. One section is for general cases requiring observation and medicolegal decision; another is for the observation and distribution of all cases of hysteria, neurasthenia and epilepsy; another is a convalescent home for neurotics who had preliminary treatment elsewhere within the war zone, insufficient, however, for the complete restoration of their mental and nervous functions. The American Red Cross contributed generously in supplying this recent formation with medical and surgical material. In a recent editorial of an Italian paper of Reggio Emilia, high praises are paid to the American Red Cross and its medical director, Dr. Joseph Collins of New York, who, being a neurologist himself, takes great interest in this matter.

"A plan is under consideration to create special hospitals for the degenerates, perverted and amoral, whose number is increasing among soldiers, not as a product of the war, but because, in the rush for enlistment, the psychologic investigation of the recruits is usually neglected. These subjects are discovered later on and brought to the attention of the medical officers, who at present cannot dispose of them, although they know by experience how dangerous they are to the community.

(b) "The Neurologic Centers: There were in Italy before the Austro-German drive of October, 1917, eight neurologic centers modeled on the French system. Since that time the center of Treviso has been suppressed, owing to its proximity to the Piave line, and three new centers were created on account of the increasing number of neurologic cases. Actually the neurologic centers are distributed as follows:

"Milan, which is a distributing center for the organic cases coming from the battle front of the fifth and first armies. It is the largest one, composed of several hospitals for a total of more than 1,000 beds.

"Pavia, 600 beds. This center is under the direction of the histologist Camillo Golgi, who went from the laboratory to give his valuable service for the solution of social problems arising from the war, and to devote himself to the present and future welfare of those wounded soldiers affected with organic neurologic lesions, who, without having lost limbs in the anatomic sense, have lost their function. These men, like the anatomically mutilated, have sacrificed their limbs. Physiologically they are crippled also, and deserve the same credit and help from their country as those who have had one or more of their limbs amputated; therefore, he called them the 'functionally mutilated.'

"The other centers are: Genoa, 200 beds; Bologna, 300; Siena, 500; Ancona, 280; Rome, 310; Naples, 600; Bari, 150, and Catania, 250.

"All these centers are equipped with modern apparatus for electromechanotherapy and diagnosis.

"A notable innovation, which started in Milan and is proving most successful, is the institution of special occupational classes for the neurologic patients. These are by no means real schools for reeducation. Their scope is to furnish those patients who are able to do something during their period of treatment with a light occupation which, without tiring them, keeps them physically active. For those patients who have either organic or functional disorders, the manual work, conveniently chosen and applied, is a wonderful therapeutic procedure, either from the point of view of the motor reeducation of the nervous and muscular system, or from the point of view of psychic reeducation of will. In many functional diseases of the nervous system, in which aboulia and psychic depression are prominent features, working is a splendid stimulus to rewaken and keep alive the individual energies and activities, which otherwise would be lost forever, and any later attempt for reeducation would prove either useless or a most difficult task.

"It would be out of the field of this article to speak at length of the wonderful work done by the Italian psychiatrists and neurologists during this war; but I will give a few data.

"There are about 20,000 patients, soldiers and officers, who are admitted in a year to the psychiatric and neurologic reserve hospitals. This number does not include those successfully treated in the neuropsychiatric sections and centers of the armies. The latter units have proved of great value in reducing the number of permanently unfit by preventing, with appropriate and timely treatment at the front, many of the sensorimotor psychoneurotics from becoming sensitive-motor neurotics, which would mean the definite loss of the patient to the army.

"V. Bianchi, consulting neurologist and psychiatrist of the second army, reports that of a hundred patients sent to his department, 50 per cent were able to return to service after a short period of treatment or furlough. Of the remaining 50 per cent, one third had to be sent to psychopathic hospitals, but only one half of these were declared insane and ultimately sent to an asylum. The other two thirds were declared temporarily or permanently unfit for service, which means that they were either discharged from the army or sent to the centers outside the war zone for medicolegal decisions.

"The problem of dealing with the neuropsychiatric invalids of war is one of capital importance. So far it has been given due attention in Italy. Aside from the help which the government has been giving to this matter, a committee for war invalids has been organized in Rome with the purpose of assisting in every possible manner those soldiers who have cerebral, spinal and peripheral nerve lesions, and especially those who because of unusual and violent emotions reported in battle became functionally mutilated, namely, the invalids of the nerves, of the sight, of the hearing, of the speech and of the mind."

PLANS FOR THE PHYSICAL RECONSTRUCTION OF DISABLED SOLDIERS

The Surgeon General, with the approval of the General Staff, announces the completion of plans for the physical reconstruction of disabled soldiers in the general military hospitals. These plans are formulated with a view to close cooperation with the War Department committee on education and special service in the work of restoring men to full or limited military service, and with the Federal Board for Vocational Education, which is authorized by the law to provide vocational training for disabled men after their discharge from the army and navy.

The records of 516 cases treated in four hospitals show 134 men able to return to full military duty, 210 fit for limited service, and 172 who are eligible for discharge. In the last group 12 are classed as helpless or institutional cases; 121 are able to return to their former occupations; and 39 will need further training to fit them for earning a livelihood. These figures show the division of responsibility in the work of reconstruction.

The task of fitting men for further military service is at present the most pressing need because wherever an able-bodied man behind the lines can be replaced by one less fit physically, but vocationally capable, a soldier is gained for active duty. The reconstruction work in the hospitals, therefore, will emphasize technical training in all lines capable of adaptation to the physical limitations of disabled men and in which employment will act as a therapeutic agent. When play and work and study will help a man to get well, this kind of medicine will be prescribed to the patient. If the work he does leads to further service in the army or to better prospects in civilian life so much the better.

The policy to be followed in the reconstruction hospitals, as announced by the Surgeon General, is that hereafter no member of the military service disabled in line of duty, even though not expected to return to duty, will be discharged from service until he shall have attained complete recovery or as complete recovery as may be expected when the nature of his disability is considered. In furtherance of this policy, physical reconstruction is defined as complete mental and surgical treatment carried to the point of maximum functional restoration, both mental and physical. To secure this result all methods recognized by modern medicine as conducive to cure will be utilized. In other words, not only the ordinary means of medicine and surgery, including all specialties, will be utilized, but also physical measures such as are employed under physiotherapy, including hydro-, electro- and mechanotherapy, active exercises, indoor and outdoor games and passive exercise in the form of massage. Provision in the form of adequate buildings and equipment for physiotherapy have been adopted in each of the hospitals.

Modern medicinal treatment does not end with physical cure. Functional restoration is the final aim of the modern physicians and surgeons. It is conceded that the physical rehabilitation of disabled men is peculiarly dependent upon their mental attitude. The more serious the disability, the greater the danger of mental depression and an indisposition to respond to medical and surgical treatment. The educational work should begin, therefore, at the moment when the man has arrived at the stage where he begins to worry about his future, whether in this country or overseas. The first problem is to divert his attention by simple recreation, through reading, pictures, games, handiwork occupations, and the like, with a view to securing a genuine interest in the attainment of some worthy end—the end most certain to hold his attention and to claim his best efforts in his future vocation. Hence, by gradual steps he may be induced to supplement his previous vocational experience by academic, scientific or technical instruction, or to choose a new vocation and begin preparation for it if such a course is necessary.

The need of "cheer-up" work in the hospitals extends to all who are mentally capable of planning for their own future. This means a relatively large proportion of the entire number. The beginning is made at the bedside with handicrafts of various kinds grouped under the term "occupational therapy." When the man is able to leave the ward and can be benefited physically by technical training, he has the opportunity of working at specific trades, either in the curative workshop, in specially provided classrooms, or out of doors.

The teachers for this work have been secured from the convalescent disabled soldiers who are already skilled in their vocations and from the enlisted personnel of the army secured by transfer or by induction of registrants disqualified for general military service but qualified for special limited service. These instructors work under the direction of educational officers chosen for their professional standing in civil life and commissioned in the Sanitary Corps of the Medical Department. The General Staff has authorized commissions for 119 educational officers for this purpose.

From the military standpoint disabled soldiers may be placed in three general classes: (1) those who can be restored to full duty, (2) those who can be fitted for limited service and (3) those disabled to the extent of unfitting them for further military service.

It is the announced policy of the Surgeon General that patients of the first class should have, when circumstances warrant it, the benefit of therapeutic treatment through play, work, and study, as may be prescribed by medical officers, in order that their morale may be stiffened, their special skills improved, their future usefulness increased and their recovery hastened.

Patients of the second class should have, whenever conditions permit and the medical officers approve, such specific training—physical and vocational—as will in the judgment of the educational officers best fit such patients for limited service of a particular kind. At present patients are being trained in general hospitals for limited service as general and vocational teachers, typists, printers, tailors, cobblers, harness makers, welders, motor mechanicians, painters, machine workers, wood workers, bookkeepers, statisticians, telegraphers, photographers, telephone operators, cooks, storekeepers, electricians, etc.

The list will be extended with the advice and cooperation of the committee on education and special service of the War Department to meet other needs as they arise. In connection with the large general hospitals there is abundant opportunity for practice in many trades and occupations. At Fort McPherson, for example, practical experience can be gained in twenty different trades. Moreover, there is immediately adjacent to the hospital a large quartermaster's mechanical repair shop, covering all phases of mechanical repair and construction to which men can be assigned for limited service or to gain experience.

Patients of the third class should be encouraged in every possible way to accept the benefits accorded them for vocational training by the Federal Board for Vocational Education. To this end they should have while in the hospital such physical training and general education as will best promote their physical reconstruction and at the same time contribute most to their vocational training. Patients who do not elect or who are not eligible to continue their education under the Federal board should receive such training as the medical and educational officers deem best in each individual case.

A clinic for the reeducation of disabled soldiers, sailors and civilians was established July 15th, at the New York Infirmary for Women and Children, Stuyvesant Square, New York City, under private auspices through the generosity of philanthropic citizens. This clinic is affiliated with Cornell University Medical College and its teaching staff includes many members of the faculty. Although it has been established primarily as a war service for the treatment of soldiers and sailors and to offer instruction to medical officers, it is also intended to be a permanent institution. At present, energies are being devoted primarily to work along the line of functional reeducation, one small room only being devoted to the occupational phase. It is intended, however, to develop this aspect of the work. Treatment is given free of charge to those persons who are unable to pay, and about forty beds are provided for patients unable to walk.

The rehabilitation division of the Federal Board for Vocational Education has opened offices in seven districts for the purpose of reeducation and placement of disabled soldiers and sailors. These districts are as follows:

District 1. Maine, New Hampshire, Vermont, Massachusetts, Rhode Island

District 2. New York, New Jersey, Connecticut

District 3. Pennsylvania and Delaware

District 4. West Virginia, Virginia, Maryland, District of Columbia

District 5. Florida, Georgia, North Carolina, South Carolina, Tennessee

District 6. Louisiana, Mississippi, Alabama

District 7. Indiana, Ohio, Kentucky

Other districts will be created as soon as the proper personnel can be obtained. The Board will deal with the disabled man as a civilian needing advice and assistance. It will encourage him to make the most of the opportunity to overcome his handicap, help him to secure a suitable permanent occupation, and will keep in close touch with him after he has obtained employment.

MENTAL PATIENTS IN LORD DERBY WAR HOSPITAL

During the first twelve months of the admission of patients to the mental wards of the Lord Derby War Hospital, Warrington, England, there were 2,429 admissions and 1,466 discharges. Of the latter, 823 were discharged to civil occupations, 154 sent to asylums, 224 transferred to other hospitals, 247 sent to home duty, and 18 died. At the end of the period, 963 were still in the hospital. An account of the work at this hospital, several statistical tables, a discussion of the different types, together with case histories, are included in a paper by Major R. Eager, R.A.M.C. (T), who is officer in charge of the mental division of the hospital. This paper was published in the July, 1918, number of the *Journal of Mental Science.*

Major Eager writes: "The usual asylum treatment was adopted as a matter of routine, but the relatively larger proportion of medical staff to patients, and the greater facility for massage and any specialized treatment than is customary in present-day asylum practice, I feel sure contributed largely to the high percentage of recoveries. Much more individual care and attention was possible on the part of the medical staff. Each medical officer had his own room for private examination of cases, thereby assuring the patient that his statements would be treated in confidence. During the interview explanations could be given to each case as to the nature of his illness, and he could be shown how to regain his normal condition. Confidence inspired like this has proved a great help in early cases. Beds in the open air were provided for those to whom it was thought rest in bed would be beneficial. As soon as convalescence was established, patients were recommended for parole, and allowed to go about by themselves in the hospital grounds and into the neighboring town, provided they returned to the hospital at the specified time. This privilege was much appreciated, and very rarely abused. The average number daily having this freedom from lock and key was 150.

"Employment on the farm and in the gardens of the hospital has been encouraged for suitable cases. About 80 to 100 patients daily have been so employed. Advantage has also been taken of the workshops belonging to the hospital, and any man having a special trade was given facilities for working at this during his period of convalescence, thus preparing himself for the work he was going to take up again in civil life on his discharge from the Army. This has helped in a large measure to establish the man's self-confidence, but I feel I should also add that the patient's convalescence must be first firmly established, otherwise it is sure to prove a failure, and the end result will be a confirmation to the patient of his disability and a protraction of the case.

"The cases received were all in the early stages of mental disorder, with the exception of the mental defectives, and even in these cases many of them showed acute symptoms superimposed on the congenital defect. A fair comparison, therefore, of the percentages of recoveries with those of civil asylum statistics cannot be made. Futher, many of the cases admitted would not have been certified for asylums in civil life, and this seems to be supported by the low percentage of general paralytics in comparison with the figures available from the report of the Commissioners in Lunacy. Many of the neurasthenics and shell-shock cases would not have been included in the uncertifiable, but it will also be seen that, strictly speaking, the only cases which did not show any mental symptoms amounted to 25, or only one per cent of the admissions. Experience gained amongst this large number of uncertified mental cases in the early stages of the disorder convinces me that the treatment of such conditions in receiving hospitals other than asylums would, if properly and carefully organized, save a large number of cases from the stigma of certification. The first essential would be an adequate medical staff to allow individual attention to every case. It has been a striking feature of the wards in the mental section of this hospital since its opening that where this was given the most contented patients were to be found. The mere visit of the medical officer to the wards and the official 'walk round' is not the way to help any cases suffering from mental disorder. It is necessary to obtain a thorough insight into the nature of each case by confidential talks with the patient, and to find out the particular circumstances which have given rise to the symptoms presented. An explanation of the same to the patient will help him to gain an insight into his condition, and it is idle to pretend that such a procedure is unnecessary, and to urge, in extenuation of the omission to search for causes, that some cases recover under 'quiet' and 'rest.'"

RECENT PERIODICALS ON RECONSTRUCTION

In addition to the numerous books, monographs and articles on the subject of reconstruction as applied to the disabled soldier and sailor, several periodicals are being issued which keep information on this subject to date. The material contained in these magazines will have especial value now, when concentrated effort is being directed in so many countries to the rehabilitation of the disabled fighting man.

Recalled to Life, published by John Bale, Sons and Danielsson of London, and already mentioned in this journal, has now become *Reveille*, edited by John Galsworthy succeeding Lord Charnwood. The first issue appeared in August and contained articles of both technical and literary interest.

The title of the *War Pensions Gazette*, London, is perhaps somewhat misleading, as the journal deals not only with the problems of indemnity and pensions, but also with those of reeducation and vocational rehabilitation. The *Gazette* has been published monthly since May 1917.

In January 1918 the Military Hospitals Commission of Canada began to issue *Reconstruction*, "published for the information of all interested in the welfare of Canada's returned soldiers." The title of the journal indicates the subject matter treated and the problems discussed in each monthly number. Many of the articles are illustrated.

The Vocational Summary began publication May 1918. It is issued monthly by the Federal Board for Vocational Education, Washington, D. C. Legislation for rehabilitation, articles by authorities, statistical tables, notes and comments upon the subject of reconstruction are included in the contents.

Carry On, a magazine on the reconstruction of disabled soldiers and sailors, is the latest of these publications, the first number having been issued in June 1918. The magazine is a monthly, is edited by the Office of the Surgeon General of the United States Army and published by the American Red Cross. Its editorial board consists of Colonel Frank Billings, Chairman; Captain Arthur H. Samuels, Managing Editor; John O'Hara Cosgrave, Editor; and Lieutenant-Colonel Casey Wood, Herbert Kaufman, Lieutenant-Colonel Harry E. Mock, Douglas C. McMurtrie, Charles J. Roseblaut. The articles are by authorities and are profusely illustrated.

Personnel, "the Right Man in the Right Place," is a new journal the first number of which appeared August 21, 1918. It is published weekly by the Adjutant General, Committee on Classification of Personnel in the Army. The object, as stated in the "Greeting" in Number 1, is "to continue and expand the relationship which the Adjutant General's Office has sustained with those officers of the Army who are striving to place each soldier where he is most needed. . . . This new journal is intended to supplant the *Daily Letters* and to supplement such other agencies as schools, conferences, visits of supervisors and all other publications issued by this office. *Personnel* will contain information on such topics as general classification work, trade testing, personnel needs of the Army, assigning men, transfers, rating of officers, officers' qualification cards and important contributions to the field of personnel."

Soldiers with nervous or mental disease will be treated in specially prepared wards or hospitals as follows: U. S. Army General Hospital No. 4, Fort Porter, Buffalo, New York; U. S. Army General Hospital No. 13, Dansville, New York; U. S. Army General Hospital No. 34, East Norfolk, Massachusetts; U. S. Army General Hospital No. 30, Plattsburgh, New York; U. S. Army General Hospital No. 31, Carlisle, Pennsylvania (formerly the Carlisle Indian School); Neuropsychiatric Wards, U. S. Army General Hospital No. 2, Fort McHenry, Baltimore, Maryland; Neuropsychiatric Wards, U. S. Army General Hospital No. 6, Fort McPherson, Georgia; Neuropsychiatric Wards, Walter Reed General Hospital, Washington, D. C.; Neuropsychiatric Wards, U. S. Army General Hospital No. 1, Williamsbridge, New York City; Neuropsychiatric Wards, Base Hospital, Fort Sam Houston, Texas; Letterman General Hospital, San Francisco, California; Neuropsychiatric Wards, U. S. Army General Hospital No. 26, Fort Des Moines, Iowa; Neuropsychiatric Wards, U. S. Army General Hospital No. 28, Fort Sheridan, Chicago, Illinois; U. S. Army General Hospital No. 25, Fort Benjamin Harrison, Indianapolis, Indiana. At the Ports of New York and Newport News, Virginia, patients from overseas will be received in special wards where they will remain until proper classification can be made and transfer to the above hospitals effected. The hospitals at Plattsburgh and Carlisle are for neuroses cases only. Officers with mental disease are cared for at the Bloomingdale Hospital, White Plains, New York, as patients of U. S. Army General Hospital No. 1, Williamsbridge; and nurses, at the Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, as patients of U. S. Army General Hospital No. 2, Fort McHenry, Baltimore. In addition to the above hospitals and wards, the Base Hospital at each cantonment has a neuropsychiatric ward where patients are cared for until transferred to one of the General Hospitals. Special provision has been made for epileptic patients, at the hospitals at Camp Mills for the Port of New York, and at Camp Stuart for the Port of Newport News.

In order that each patient may have an opportunity to recover in a military hospital, no patient with nervous or mental disease will be discharged, transferred to a state hospital or to the St. Elizabeths Hospital, Washington, D. C., until after four months of treatment in a military hospital, unless he recovers or his friends desire to make special provision for his treatment, with the exception of general paretic and the epileptic insane who will be transferred to St. Elizabeths Hospital.

ABSTRACTS

STUDIES IN PERSONALITY AMONG FEEBLEMINDED DELINQUENTS SEEN IN COURT. By V. V. ANDERSON, M.D., and C. M. LEONARD, M.D. *Boston Medical and Surgical Journal*, 179: 192–97, August 8, 1918.

The authors are the Medical Director and Assistant Medical Director of the Municipal Court of Boston. For the purpose of this study, case records of 100 feebleminded women, ranging in age from 17 to 55 years, were taken. The basis upon which a case was selected was that there should be at hand enough information to determine the general character of her behavior, and also her abilities and disabilities. The article is not a discussion of the seriousness and extent of feeblemindedness, but purposes to call attention to the value of certain facts other than the mere diagnosis of feeblemindedness in the consideration of the case of a feebleminded delinquent in court. The authors emphasize the fact that we need to know more about an individual than that he is feebleminded. Feeblemindedness does not necessarily carry along with it social maladjustment, nor is it an adequate explanation for criminal behavior. A better understanding of the individual differences presented by feebleminded persons is necessary, and also a greater knowledge of those elements of personality that make for successful or bad adjustments.

The first statistical table giving the chronological age of these 100 feebleminded delinquents shows that 69 of them were between the ages of 20 and 40. From the next table, which classifies them according to mental age, it is found that one is between 7 and 8 years; 11 are from 8 to 9; 42 are from 9 to 10; 26 are from 10 to 11, and 20 are from 11 to 12 years of age. A thorough psychiatric study was made of each case before applying mental tests. The mental level was determined by use of the Yerkes-Bridges Point Scale, Goddard Revision of the Binet Scale, Healy's supplementary tests, tests of school knowledge and general information. A history of each case was also taken. The case histories showed great differences in behavior.

The third table shows that 16 were steadily employed, 38 changed positions frequently, 35 did not work, and that 11 did housework at home.

Eighty-two used alcohol, 5 of whom used drugs as well, while 18 used neither. Along with the use of alcohol, sexual irregularities were almost invariably found, 81 being either wayward or especially promiscuous.

It was found that 20 were first offenders, 12 were second offenders, while 68 were recidivists. In this last group from 25 to 50 arrests were common.

The cases were divided into four groups according to their social adjustment as reflected in their behavior shown by their life histories and court records. Of these 100, 19 showed good or fair social adjustment, taken in the very broadest sense, and 81 poor or bad social adjustment. Although all of these women were feebleminded, their modes of behavior differed very greatly due to innumerable social and environmental factors.

"On the basis of our four main headings, we find that those with good social adjustment (4%) showed good manual dexterity, were active, ambitious and not combative. In their work they were persevering and industrious; were usually sincere, conscientious, honest and truthful; were cooperative, accepted authority, and showed a willingness to be guided by advice; were earnest, kind and sympathetic, respectful, trustful, considerate of others, appreciative, acknowledged mistakes, and made an earnest attempt to profit by them. In some instances, these individuals were suggestible, sensitive, emotional and easily discouraged; but their principal difficulty was their arrested intelligence. All of these individuals worked steadily; none were alcoholic; none could have been considered immoral women; and none showed a tendency to a repetition of their offense.

"Those with fair social adjustment showed the majority of the above characteristics, but with less frequency than found in those with good adjustment; with a certain intermingling of undesirable characteristics —lack of ambition, indolence, untruthfulness, frivolity, capriciousness, self-pity, lack of appreciation. The majority of these individuals were steadily employed, though some changed positions very often; nine of the fifteen cases had had illegitimate sexual relations, though none were sexually promiscuous. Seven of these cases used alcohol at irregular intervals. There had been no tendency in these cases to a repetition of arrest.

"Those with poor adjustment showed a higher frequency of laziness, poor manual dexterity, lack of ambition, anger easily aroused, and combativeness. In their work they were more inclined to be indolent and procrastinating; showed a tendency to be dishonest and untruthful, were less agreeable to authority; were inclined to justify themselves and their acts; and showed little tendency to be guided by advice; were more often inconsiderate of others, stubborn, suspicious, lacking in appreciation, and rarely were willing to acknowledge their mistakes and make an honest effort to do better. None of these individuals were steadily employed; the majority changed positions frequently, not remaining long at any place, and in some instances did not work at all. Forty-nine out of 52 cases were alcoholic; and three were drug users. Forty-five out of 52 cases were either sexually wayward or especially promiscuous. Practically all of these persons showed a tendency to a repetition of their offenses—some to a great number of times.

"Finally, those with bad social adjustment showed the above undesirable characteristics in a more marked degree and with greater frequency than exhibited by those with poor social adjustment. The majority never worked at all—gained their living by simpler methods. All used either alcohol or drugs; 27 out of the 29 cases were immoral women; and all were repeated offenders, upon whom the court had tried every measure for proper readjustment at its disposal, and with no apparent success."

Three main types of personality were found in these 100 cases: (1) the feebleminded individual with little difficulty of personality whose mental defect is the outstanding characteristic, (2) the unstable emotional group and (3) those with very grave difficulties of personality.

The type of behavior shown by these 100 individuals seemed to correlate less with their chronological and mental ages than with trends of personality. The authors state that although some feebleminded persons seem to get along fairly well without supervision, the majority of feebleminded delinquents seen in court are institutional cases incapable of living in accordance with the social standards of the community. "A well-rounded, thorough-going study of the possibilities of each individual delinquent, though he be feebleminded, is necessary for an adequate adjustment of his case.

THE TRUE EPILEPTIC. By L. PIERCE CLARK, M.D. *New York Medical Journal*, 107: 817–24, May 4, 1918.

The article is a summation of studies investigating the fundamental make-up of essential epilepsy. In addition to a most intensive clinical research in fifty of the author's most recent cases in private practice, he embodies the material recorded from several thousand cases examined in special and separate epileptic colonies as well as in private practice. The study of the last fifty cases was begun before the onset of the seizure life of the individual. A few cases were studied immediately after onset of convulsive life.

In the opening paragraphs, the writer calls attention to the defective instincts, which are generally accepted as constituting the epileptic make-up or constitution—"egocentricity, supersensitiveness, marked emotional poverty and rigidity."

The subject is discussed from the broadest of viewpoints, the data paralleling records, which can usually be made only in a special epileptic hospital, where there are intimate contacts with the everyday life level reactions of the epileptic.

Beginning with infancy, the difficulties of objective studies to detect "demarcations of the epileptic character" are mentioned, and the suggestion is made that their presence is shown by the "fits of meaningless crying" which is so often noted in the histories of those who subsequently develop epilepsy.

In childhood the make-up becomes so dominant and rigid that the families are quick to yield to the child's peculiar demands. Very few of the series showed normal mood or deportment. Physically they developed normally. Intellectually three fifths presented a fairly normal school record, and two fifths were somewhat retarded in school due more to their rejection of the monotony of scholastic training than to defective endowments.

The group as a whole carried their innate defects of infant personality into their school and early adult life, until the conflicts and inadaptations incident thereto caused the final development of seizures. Usually the personality, which in all cases was peculiar in its evolution, reached its zenith and showed deterioration before the onset of attacks. In work and play there was little spontaneity, no special grace, dexterity or unusual skill; artistic attainments were lacking, and a proper insight into his shortcomings was denied the patient because of his outstanding egocentricity. The patients either demanded leadership or regressed to antisocial tendencies. They were largely inaccessible, with few tendencies to unburden themselves, and as interests failed in the reality of environments they lapsed into the phantasy habit.

The mood of the potential epileptic as contrasted with that of the active epileptic was cheerful rather than sullen. There was incompetency to meet adult levels of emotional life, few developing in this respect beyond the stage of puberty. It was found that these potential epileptic characteristics, were usually present in some degree in one or both parents. From an hereditary standpoint the writer considers the "make-up" as recessive in type.

Setting forth by their lives and teachings, epileptic traits and tendencies, are mentioned Dostoievsky, the Russian author, Mother Ann Lee of Shakerism, Joseph Smith, the Mormon Elder, and the prophet Mohammet.

As an aid in eliciting the details of a frank epileptic personality, and the presence of defective instincts, prior to the onset of seizures, the writer has prepared as a questionnaire a modification of the Hoch-Amsden personality outline.

The therapeutic suggestions make the article especially hopeful in controlling seizures, and preventing deterioration.

THE LIMITATIONS OF THE PSYCHIATRIST. By JESSIE TAFT, PH.D. *Medicine and Surgery*, 2: 365–69, March 1918.

"To the social worker who has been nourished, or shall we say starved, on the attenuated psychology of the college and university, the psychology which is meeting the test of life in the hands of the psychiatrist comes as a sudden illumination like the awakening of adolescence.

Fired with the zeal of the convert, she burns to pass on a gospel which can so clarify mental and social life. To her the psychiatrist is a god, holding in his hands the knowledge of good and evil. But as she turns to him for help with her infinitely complex human problems, she has to admit that he is a finite god, sadly limited by time, space and physical body. Moreover, he is a god too often not fully conscious of his own godhead, not yet aware of the scope of his kingdom nor of the need to compensate for the limitations inherent in his finiteness.

"The social worker is not always an over-confident aggressive creature who blunders in where angels fear to tread, but undoubtedly circumstances have forced her to grapple with problems in many fields for which she cannot claim special fitness or technical training. Because she works in the interest of the under dog she is constantly having to fight his battles in courts and clinics, in prisons and hospitals, in laboratories and legislative halls.

"She is not a lawyer, but she finds herself knowing something about law, and in spite of herself acquires opinions about the functions of judges and courts, actual and ideal. She is not a physician, but unless she can comprehend the physician's plan for her case, he runs the risk of losing what he has gained in hospital or clinic.

"She cannot afford to take the respectful, unthinking attitude of the conventional hospital nurse. She must have a mind of her own, even in medical matters. Who is there to carry out the doctor's intentions if her judgment is withheld? The nurse has only to follow definite directions within a simplified, controlled environment, thoroughly known to the physician. The social worker must understand and be able to interpret the physician's orders in terms of complex, uncontrolled conditions, known only to the person who is in daily and immediate contact with them. To the conservative bystander it may seem presumptuous and even dangerous for the social worker thus to assume the responsibility of making medical interpretations, but the fact remains that in many instances if she does not, nobody will.

"Thus it happens that when the social worker discovers the psychiatrist, as she is beginning to do, although she is for the moment bewildered by the flood of light he throws upon her problem, the habit of thinking for herself has become too ingrained to be abandoned suddenly. Like the Mother Goose cat, she is able to look her deity over with a calm and critical eye; and, as has been the way of human beings with their gods, at once begins to ponder how she can use him to the best advantage. She sees quite clearly that he has his limitations and that much of his divinity is potential. To herself she even dares to admit that he needs her help and her experience. It is not that she is so lacking in humility or appreciation of the highly technical nature of the psychiatrist's work, but simply that her position in the center of things, close to the daily commonplace life of humanity, gives her a point of vantage and a background which the specialist acquires only with effort.

"It is in the clinic that the social worker discovers the limitations of the psychiatrist. She becomes aware of them first in her own vague feeling of dissatisfaction with clinic results. The psychiatrist is human and approachable beyond the wont of physicians. He listens patiently and sympathetically to her histories. He examines her patients as courteously and carefully as though they were private cases. He gives her diagnoses put in language as simple as possible for her benefit, and yet she is not satisfied.

"As she tries to analyze her own reaction, she finds his dissatisfaction apparently due to a repressed impulse of her own. She is definitely conscious of wanting to do something to the psychiatrist. She feels something lacking in him which she could supply, if professional etiquette allowed. 'What is that something?' As she puts the question to herself, her mind is flooded with a host of things which she now realizes were things she had wanted to say to the doctor about her last patient —and yet she had given the history in some detail. What was the meaning of all this pressure of ideas? Why should she feel the need of saying these things over again? It would not change the diagnosis.

"Then it came to her, the significance of her restless, unsatisfied state. True, she had told the patient's story and the psychiatrist had listened smilingly; but had she gotten it over except as a theoretical background for his diagnosis? That was why she felt she must do it again, that she must make this man realize her patient as a living problem, which was hers to solve in some practical fashion. The psychiatrist had said, 'Probably beginning dementia præcox, but not advanced enough for commitment,' and had gone on to the next case. But her job had not stopped there; it had only begun. She could not get rid of her problem by diagnosing it. The psychiatrist could retreat to his office or his hospital, leaving the clinic and its problems far behind. The beginning dementia præcox patient would not be sitting on his doorstep the next morning, waiting for something to be done. He would not have to face the practical question of how a living was to be earned until commitment should become possible or of how the intolerable family atmosphere was to be made more endurable.

"In such a fashion does the social worker become conscious that it is understanding of her problem, of the patient in his social setting, that she craves from the psychiatrist, and then in a flash she sees that, after all, it is really not so much her problem as it is his—none the less his because he does not recognize it.

"If the dementia præcox case were in the hospital or belonged to a family sufficiently well off to afford the services of a psychiatrist as a private physician, the psychiatrist would be controlling every detail of that patient's life, within certain limitations. At least he would consider such control part of the treatment. In the hospital, the artificiality and simplicity of the environment would make this possible; in private practice the wealth of the patient would guarantee a certain amount of control over the environment. But in both cases a false and misleading simplicity is introduced which does not prepare the psychiatrist for life in the raw as he meets it in the clinic.

"This is what the social worker has to get over to the psychiatrist and if she possesses courage and easy access to the clinic, she will return with her beginning dementia præcox patient and represent the case so that the necessity for concrete action and the social and medical complications involved in any action cannot be evaded. The psychiatrist will be uncomfortable under such pressure, and, until he has been through a long course of social training, will not do much except begin to realize his own inadequacy. He may indicate that a beginning dementia præcox case, although *a priori* rather hopeless, should theoretically be subjected to new and powerful social stimuli. This would mean removing the patient from his present environment. If the social worker presses for more concrete directions he will probably say in desperation, 'Oh, you can't do much harm and you may do some good. Go ahead. Do anything you like.' And so the social worker, whether she likes it or not, finds herself in the position of doing the work of the psychiatrist in the life of this patient because it is impossible for the patient to be abandoned, and because the psychiatrist cannot follow the patient into his home to bring about the conditions which, theoretically, he believes might stimulate this shut-in individual to a renewal of his attack on reality.

"Thus carelessly, almost without realizing what he is doing, the psychiatrist puts into the untutored hands of the social worker the most complicated and experimental work of his profession. If she does not choose to report back on the case, he will probably never think to ask about it. If she gets valuable and startling results he may hardly take time to comprehend the significance of her enthusiastic account. He is initiating mental treatment through another person. There is bound to be some significant outcome. Yet for the most part he is not consciously using this person as an agent to carry out the best that he can give—to keep him in touch with the patient and to report back results good or bad. This *ought* to be a controlled, conscious process, a serious method of long-distance medical treatment. It frequently *is* a careless semiconscious makeshift.

"The reasons for this are not difficult to find. Each psychiatrist is doing the work of ten men. He is snowed under with the problems of many patients. Either he is completely absorbed by his private practice, consisting chiefly of patients whose intelligence and financial status enable them to use his knowledge to the best advantage, or he is responsible for several hundred patients in a hospital whose mental condition is much worse than that of his clinic cases and who more than occupy his time and attention. The hospital patient, moreover, is an individual removed from his social setting and held by law in an artificially simplified situation which the psychiatrist controls. When the patient leaves the hospital the psychiatrist is absolved from further responsibility. He is not compelled to treat his patient as he exists in real life—a member of a family, an economic factor in industry, and a citizen of the state. This means that the hospital psychiatrist tends, by his training and experience, to see individuals rather than social units, and to deal with disease entities rather than with the concrete problems of social maladjustment. It is not strange, therefore, that in the clinic he has to learn to be practical and unevasive in the face of social complications. The psychiatrist in private practice is less likely to be out of touch with the real life of his patients, because he is not limited to the hospital environment, but he, too, is in danger of being misled by the ease with which wealth, culture and social position can be used by him to produce the setting he recommends.

"The psychiatrist in the clinic, then, as the social worker sees him, is at the present moment tremendously handicapped by two things: first by his lack of experience with social problems in the concrete; and second, by his consequent failure to grasp the significance of the part played by the social worker who follows up the clinic case.

"There are those who deprecate the intrusion of the social worker into the field of the psychiatrist, who say that whatever she does she must never presume to know anything about mental disease or in any way undertake what might be interpreted as treatment, ignoring completely the fact that whatever is done with the patient after he leaves hospital or clinic is inevitably treatment, whether so intended or not. Any kind of social service in the interest of the patient is bound to have its mental effect for good or ill. The only question is, Shall this effect be obtained by the social worker acting in as complete ignorance as possible out of respect to the psychiatrist and fear of invading his province, or shall it be done with the full knowledge and cooperation of the psychiatrist, definitely using as a tool the intelligence of the social worker to the limit of her ability? The psychiatrist is little more than a diagnostician unless he realizes that to treat the clinic patient he must control the social worker. Either he follows the case through her or she becomes the psychiatrist.

"If the psychiatrist were able to be absolutely consistent and absolutely thorough in his treatment, he would follow his patients one and all out into life as the social worker does, and deal at first hand with all the complications of adjustment to home, friends and work. This is practically impossible, because he is so limited numerically and temporally. Since this is so, is it not the part of wisdom for the psychiatrist to recognize his own limitations and endeavor to make as intelligent as possible the agent through whom, whether he likes it or not, he must ultimately act?

"The social worker is the last one to wish to criticize the psychiatrist. It is because she feels so keenly the need of his assistance and knows so well that what he has to give is priceless, that she is impatient to have him shake off the institutional bonds which hold him. She craves only to see his potential power realized and asks no better fate than to be an intelligent instrument for his use when he comes into his kingdom."

THE BROADENING FIELD OF MENTAL MEDICINE. By WILLIAM BURGESS CORNELL, M.D. *Medical Record*, 94: 329–31, August 24, 1918.

The author, who is Medical Superintendent of the New York City Children's Hospital and School, Randall's Island (more recently appointed Physical and Medical Diagnostician of the New York State Department of Education), notes a psychiatric renaissance in both medical and lay circles. He discusses the present field for psychiatry and indicates some of its greater opportunities in the near future. Psychiatry has been too generally regarded as something separate and apart from general medicine, he writes, and the general attitude held towards it by the profession and the public has been one of apathy or antipathy, ignorance and superstition. But, fortunately for both patient and physician, he observes, a new spirit is discernible. Among other observations, Dr. Cornell writes:

"After many dormant years this country at last awoke to the advantages of the European psychiatric clinic in close touch with the university and general hospital, and we note the establishment of the Psychopathic Hospital at Ann Arbor, Pavilion F at the Albany Hospital, Boston Psychopathic Hospital, and the Phipps Psychiatric Clinic, all within a decade. It is difficult to realize what a great advance all this represents, so rapid has been the march of events. With new ideas and new hopes, asylums became hospitals, physical restraint began to disappear, and the application of individual treatment as for many other sick patients was inaugurated. With diversional occupation in great variety and a general employment of a large majority of patients, life in a hospital took on new interest for patient, nurse, and physician and gave far better results in recoveries and improvements. The establishment of clinical and pathological laboratories meant greater accuracy in diagnosis, better study of cases, and a more rational and effective therapy, and medical school, general hospital, and mental hospital were brought closer together.

"The psychopathic clinic in proximity and cooperation with the medical school and general hospital has stimulated and facilitated the teaching of psychiatry and is greatly increasing the number of medical students who choose it as a career. The psychopathic clinic, easy of access with voluntary admittance, has also done much to dissipate popular superstition and misconception concerning mental disease. But the psychiatric renaissance has reached out beyond the institution, and here the field broadens.

"It is now about ten years ago since the first organized effort to supervise and assist discharged or paroled mental cases was made in New York. The value of after-care was at first slow to be appreciated, but of late it has gained in Massachusetts, New York, and Maryland an impetus that will give it widespread application. . . . Organized first as a private charity, the State of New York several years ago took over the after-care work that had been begun in 1906; and it is now a regular part of the hospital routine. In 1915 New York and Massachusetts State Hospitals greatly increased their sphere of usefulness by inaugurating dispensary clinics for mental and nervous cases held sometimes at the institution, but often in some city within the hospital district. This innovation, added to the placing out and after-care service, marks a new epoch in psychiatry that will prove to be also an important factor in prevention and will bring the hospital still closer to the public.

"The great modern trend of medicine toward prevention has been shared in prominently by psychiatry with large forces actively working in this direction. In addition to the state hospital and its newer ramifications above referred to should be mentioned the social service departments of psychopathic hospitals, of which Boston, Johns Hopkins, and Bellevue are excellent examples. Mental Hygiene Societies, notably in Connecticut, Illinois, Maryland, and Massachusetts and The National Committee for Mental Hygiene, are doing a great public service in disseminating the knowledge gleaned from the hospital, clinical laboratory, and other research agencies. Of the latter, two in particular should be mentioned, the Eugenics Record Office, and the Vineland Laboratory. Both have performed most valuable services in the study of heredity, particularly in strains exhibiting insanity and feeblemindedness.

"It is particularly noticeable how in recent years the focus of interest of psychology and sociology has been toward the deviate and subnormal, and we hear much of practical economic and medical psychology, the latter sounding very much like psychiatry. . . ."

"There is probably no branch of medicine which has made greater strides into prominence than psychiatry. Within a few years, from the obscurity of institutional isolation it has emerged to become of widespread value and application in the community. The future seems to promise an even greater field of usefulness."

THE VALUE OF MENTAL, PHYSICAL AND SOCIAL STUDIES OF DELINQUENT WOMEN. By EDITH R. SPAULDING, M.D. *Journal of Criminal Law and Criminology*, 9: 80–97, May 1918.

In this article eight case histories are presented of delinquent women, chosen not on account of unusual symptoms or unexpected findings but as representing types found in all large groups of delinquents. Two are cases of mental disease; the third, mental defect; the fourth shows a psychoneurosis; the fifth is a neuropath; the sixth has a manic-depressive temperament; the seventh is a colored girl with great emotional instability and in whom racial primitiveness is dominant; while the last one shows the effect of environmental influences upon a woman of normal mentality with no evidence of inherited tendencies toward physical or mental disease, or mental defect. Each history is presented in detail and summarized and the requirements for the adjustment of the individual presented.

In the general summary that follows the presentation of these eight cases, Doctor Spaulding advocates the following as our greatest needs at the present time:

(1) "Clearing houses, or laboratories, where psychologists, sociologists, psychiatrists and other specialists may make complete studies of all cases. These should be in connection with courts for the examination of cases before commitment as well as in penal institutions where a more detailed study can be made after commitment. We believe there should also be in connection with every reformatory or penal institution a psychopathic hospital where cases which show abnormal mental characteristics, but which belong neither in hospitals for the insane nor among the general reformatory population, may be cared for during their entire residence in the institution.

(2) "Institutions for the feebleminded, or suitable colonies, in every state in the Union sufficient to care for the mentally deficient individuals who are unable to support themselves, and at the same time protect themselves from the temptations of life in the community.

(3) "Psychopathic hospitals should be established in all large cities for the diagnosis and treatment of all cases showing abnormal mental characteristics, and to aid in preventing the development of mental disease.

(4) "Increased facilities for supervision on probation so that every case which has the capacity to adjust himself to social conditions may be given every possible chance, and institutional treatment used only as a last resort.

(5) "Increased facilities for supervision on parole so that the individual who comes out of the protected environment of an institution will not be plunged immediately into an unprotected environment to which he will be unable to adjust himself at once.

(6) "Increased resources in institutions for reeducation along academic, domestic and industrial lines as well as for the treatment of physical disease and abnormal mental conditions, so that when the individual is returned to the community, he will have developed to the greatest extent possible his mental, physical and social capacities. There will be then

less danger of his being a menace to the public from a physical standpoint, and economically less danger of his becoming a public charge."

The author would enlist the enthusiastic support of the public in these measures. Women especially, she says, should come to appreciate the needs of the large numbers of those women confined in industrial schools, reformatories and penal institutions, as well as those who may be prevented from entering these institutions.

"There is much to be accomplished in the field of criminalistics, and its accomplishment depends largely on the men and women in the community who appreciate the situation and who are ready to take their share of responsibility and advocate the constructive reforms which we all know are needed."

BOOK REVIEWS

Education of Defectives in the Public Schools. By Meta L. Anderson. New York: World Book Company, 1917. 104 p.

This work bears the marks of being written by one who knows the feebleminded child and also the theory and practice of teaching. From the start and throughout the book the author makes it emphatic that it is important to begin very low down in the development of the mental processes of the feebleminded child; that few teachers not especially experienced with the feebleminded will be able to anticipate how low down this is. She also dwells upon the importance of moving steadily forward to higher problems as lower ones are mastered.

Even the amateur, if he will carefully read these pages, will be convinced of the difficulties of training defective children. He will be satisfied also that feebleminded children can be trained in considerable numbers to useful work, and that this training can be accomplished in the public schools if provision is made for it.

The work deals primarily with the organization of the school for defectives, its curriculum and the manner of handling subjects and pupils. A very brief chapter sets forth the method of selecting the children. The striking point of the chapter is a chart whereby teacher and principal set forth in a form that strikes the eye immediately the backwardness of the child offered as a candidate to the special school.

A strong plea is urged for the special school in a city system as against special rooms. The great advantage to be derived from this organization is the possibility of the departmental division of the school. The kindergarten designed for children of mentality from two to four years is organized on the basis of Seguin's list of sense-training devices. Considerable emphasis is laid upon teaching the habit of personal cleanliness. The curriculum is not mapped out in detail. It is rather a discussion of the philosophy underlying the training of children little in mind but with large bodies, and this philosophy is illustrated with a considerable amount of school-room practice.

The division of the special school provides five departments: (1) the kitchen, (2) the shop, (3) the gymnasium, (4) the room for academic work and (5) the manual training room. The author urges the training of every boy and girl in each of these five departments. Girls, she urges, should have the training in woodworking if, as is commonly urged, this work is for the purpose of "making the brain strong," and to say that girls do shop work poorly is a very good reason for urging that they be trained in it. Likewise boys should have the training of kitchen work.

The practice of keeping the room and all utensils therein in a state of hospital cleanliness is really excellent training for the careers some of these boys will follow. The habit of cleanliness thus taught makes some of them excellent bakers' and cooks' assistants. Furthermore this habit of cleanliness extends to the person and to the home.

The gymnasium is made the center for musical as well as physical training. The tactful beginning with the songs the children like, the author shows, may be made the means of cultivating their interest in good music.

In the academic work, nature study and speech control are to be made more emphatic than reading, writing and figuring. She dwells upon the brilliant attainments of a Vineland teacher in arithmetic, and this teacher's chagrin a few years later in finding not the least relic of his wonderful accomplishments. The fact is that the academic work is to be confined so far as possible to such things as become concretely valuable, in language and number work, to the child for his practical activities. The academic work is always keyed up a bit beyond this point by the demands of parents who do not understand the psychology of the defective mind.

The manual training room is the center of such practical arts as weaving, basketry, sewing, including machine sewing, chair caning and brush making. Weaving is made the introduction to both basketry and sewing. It is in this room that the girls and boys alike make most definite preparation for the last year in the school, which is called the trade school. But this room, like the carpenter shop, is kept free from the idea of teaching a trade. Always and everywhere the object is to develop the mind of the individual pupil, and it is always kept in mind that his weak mentality can be brought out most effectively through the use of eyes and hands working in conjunction.

We cannot read this plan for the education of defective children of the city in conjunction with the public school system without being impressed with the unwarranted burden which is placed upon such a school. There is no state in the Union which does not lay upon such a school problems like the one instanced on page eighteen where a teacher called at a home at noon to ascertain why the boy had been absent in the morning. "She found four naked children in the room and the feebleminded mother fumbling a heap of old clothes in the middle of the floor, trying to find something that the children could put on so that they might go to school in the afternoon. . Apparently she had been at it a good part of the morning but had not made much headway." Other similar instances occur on pages ninety-six and ninety-eight. Such a social situation cannot be helped much by the public school, nor by any private, city, or county child-rescuing agencies. It is important that the state should take charge of such a mother and prevent her bearing more children. It is also important that such children should have a training school which would at the same time constitute a substitute for a home, which they have not at present.

This situation raises the further question with regard to the special school for defectives in a city system as to whether it should not occupy the activities of the children more than five hours a day for five days in the week, and for at the most forty weeks in the year. These children are vastly more dependent upon the training activities of their school for what they make of themselves, than is the normal child. They also move very slowly. It is, therefore, a question whether more of their time should not be required at the school. Certainly one conducted with the wisdom planned by this author could easily secure their attendance for longer hours.

THOMAS H. HAINES.

CRIMINOLOGY. By Maurice Parmelee. New York: The Macmillan Company, 1918. 522 p.

This book is the latest contribution from the facile pen of Professor Parmelee. The present work is a companion volume to *Poverty and Social Progress* by the same author.

Like most of his works, it is a readable, comprehensive statement of the present status of the science of criminology. The book is well gotten up with a very satisfactory bibliography which the author modestly calls a "partial" one. In this he sacrifices pedantic completeness to good judgment in selection. The book will undoubtedly fill a long-felt want for a readable comprehensive account of this subject kept within reasonable bounds.

The work is divided into six parts entitled *Nature and Evolution of Crime, Criminogenic Factors in the Environment, Criminal Traits and Types, Criminal Jurisprudence, Penology,* and *Crime and Social Progress.* It also contains two appendices.

As in his other works, Professor Parmelee emphasizes in his book on criminology, the biological factors which are concerned in the production of those social disorders summed up in this term.

It is natural that in presenting in so brief a form so large a subject, here and there topics will be passed over in a more cursory manner than the reader might wish; but the references to the literature will inform him where he may find a more complete and detailed account of those subjects.

As an introduction to the study of criminology, this book may be recommended to those who are unfamiliar with the subject, while for the more experienced worker, it will be useful as a brief and concise résumé of the manifold aspects of the science.

HERMAN M. ADLER.

THE CHILD AND THE WAR. By Cecil Leeson. London: P. S. King and Son, 1917. 69 p.

The subject of this monograph is the increase of delinquency among children in England since the beginning of the war. That juvenile delinquency has increased to a degree sufficient to cause grave concern is shown very plainly by the results of social investigations, court and official records.

In the first section of the book are set forth the facts as collected, with a discussion of causes. Tables and diagrams are used to illustrate the facts presented. The disquieting feature of the data at hand is that the number of juvenile offenses increases largely each year and that there is an actual increase in wrongdoing and not in prosecution alone.

Public sentiment, the author tells us, tends to take too light a view of children's offenses. Persons defrauded are reluctant to prosecute because the offender is a child. "While one cannot withhold a certain amount of sympathy from their point of view, it should emphatically be said that the sentiment is a false one; for the result is that when, after repeated offenses, the child is ultimately brought to court he is almost hopeless, whereas, had the first offense been followed by prosecution, his reclamation would have been more assured. In forming an opinion, therefore, on the seriousness of the cases here enumerated, it must be borne in mind that the offenses are such that the prosecutor, because of his sense of duty, or because he feels so aggrieved, considers it worth while to lose his own and his witnesses' time, and almost inevitably to incur pecuniary loss, in order to attend court to prosecute."

Two interesting facts connected with this increase of delinquency are mentioned. One is that the darker months, from November to February, show the greater number of cases. Not only does "the wrongdoer love the dark," but doubtless the darkness enables many to escape capture. The other is the effect of war on the police force. Although police work is relieved by a decrease of adult offenders, war has claimed many from the ranks of the police. Those who are left have not time for anything but absolutely necessary work. Preventive work is practically impossible.

The causes, in general, are described as "chiefly to be found in the withdrawal from child life of adult personal influence, and in the curtailment of those social and educational influences that have hitherto occupied so large a part of the child's life, and on which those responsible for him had come to rely." Cases illustrating different causes are cited from records. An inquiry into the parental condition of 400 offenders showed that in two instances in every five the father was in the Army or the Navy. In some instances where the father is in France the mother works all day in a factory, since the Army allowance necessitates this. In other cases the family has been forced to move to a much inferior neighborhood. Some records reveal the fact that father and mother are both employed all day and that the children spend most of their time in the street or at the cinema. While many cases show the effects on the home of the withdrawal of the influence of the parents and older brothers and sisters, in an appreciable number of homes the father and mother still remain, and yet conditions are not normal. The children are led astray by their association with those from disorganized homes. Again, the impaired educational system contributes to disorder and delinquency. Lack of discipline at home tends to similar shortcomings in school. Many school buildings have been taken for hospitals. Many teachers are in the Army. School hours are curtailed and half-time sessions result—a condition almost new for young children in England. Children find themselves with more time than ever on their hands, with diminished recreational facilities and lack of proper supervision from all sources. The result is increased delinquency. Though the increase is but now ascribed to lack of occupation, it is also due to improper occupation during certain ages.

The abnormal demand for boys as laborers has released from school from 150,000 to 200,000 lads between the ages of 11 and 13. Delinquency has increased in greater proportion among those of the ages of 12 and 13 than among other groups. Long hours and higher wages now being earned are demoralizing. The chief offense directly attributable to these conditions is gambling. Having entered into work, the boys must adjust to a new environment. In school the boy was surrounded by those who were interested in what he did, who were responsible for him and he to them. Correction was given when needed. The standards of conduct were quite different from those in workshop life. Here he is under less restriction than at home or at school. For his overseer he has less respect than for the teacher. At work he may talk; he may leave his bench without permission. Nearly everyone swears. Foul language and coarse habits prevail. This leads to lowering of other standards. And what is worse, the boys are often sacrificing youth, physique, efficiency and character to work that is teaching them nothing, that leads to no trade or profession.

There is an interesting discussion of causes for the increase of delinquency at night, depending on the fact that "war has evoked a spirit of adventure in children." This is fed by the prevailing war talk among their elders.

"There is, indeed, one class of children, the subnormal, on whom the effects of the war itself are much more serious. With the weak-minded there is a stress-point beyond which their mentality breaks down; their balance, just stable enough to sustain the ordinary demands of life, is destroyed when subjected to undue excitement—and the war has furnished such excitement. It is doubtful whether sufficient recognition is ordinarily given to the proportion of juvenile delinquents who fall short of normal mental equipment; certainly, there are no signs that the fact has been allowed for in investigating the causes of their increase during the war."

The author closes this section with a thoughtful discussion of the evils, real and alleged, of the cinema. Criticisms come mainly from two classes: first, those who object, as did many well-intentioned but ignorant, in early Victorian days, to the novel. The second group raises objection to permitting children to witness pictures, partly on moral and partly on hygienic grounds. To the objection of the first group, that the pictures are keeping alive a tradition bequeathed by "Deadwood Dick" and the other penny dreadfuls (not half so dreadful as some of the things said about them), is the answer that the penny dreadful did cause the child to sit still and read for an hour or more at a stretch. It formed in him the reading habit. Deadwood Dick at one end of the road meant Scott and his company at the other. On the score of hygiene, are the darkness, poor ventilation and crowding of many of the houses, tending to the propagation of disease; late hours, producing lack of sleep and a weary mind and body for the next day's task. As a mental influence, the pictures are too sensational; children shown how wrongful acts are committed are tempted to imitate them; and the attraction is so alluring that the children will do anything to get the price of admission.

The interruption of club work, the closing of playgrounds and the discontinuance of public games leave the boys without proper outlets for recreation or supervision for it and again release them to the streets. This work of course depends largely upon the services of young men, who are now in the Army and Navy.

In the second section remedies described as palliative and constructive are considered. The author claims no complete method but offers freely what he believes to be helpful. Remedies, the author states, are often more thorough than immediately practicable. The test of a remedy is, Is it practicable now?

The difficulties of restoring the school system are noted. There are not enough buildings, and building operations are greatly restricted. Male teachers are largely at the front and women do not fill all the vacancies satisfactorily. Housing reforms would be influenced by the same restriction as school buildings.

Delinquents are sometimes fined by the magistrate, whipped, sent to a reformatory or industrial school, or released to the care of a probation officer under the "Probation of Offenders Act." This act is discussed at length. It is an excellent one for children, provided the whole of the act is used and not merely part of it. The constructive friendship of a probation officer is just what is needed in the lives of these children. They require guidance, interests and an ideal. The Probation Office should supply all three. Probation officers, generally, had too much to do before the war; it goes without saying that they have now many more cases than they can handle adequately. The need for increasing the number is more than ever urgent; both professional salaried officers and voluntary ones are needed. The objection to increasing the number of salaried officers is that economy is the watchword of the day. It is inadvisable to increase the number of officers for this work since juvenile delinquency will surely decrease after the war. To this latter objection is the answer that the number of juvenile offenders is likely to remain above normal for some time, and that the war will produce many orphans, a condition conducive to delinquency. Moreover, adult delinquents will become more numerous. To supply these salaried officers, men above military age are suggested. Younger men would do better work but are not available. All available voluntary help should be used, both men and women.

It is suggested that the juvenile courts should attach to themselves young ministers of all denominations suitable for work with children, and should keep registers, geographically arranged, showing those who labor in the districts in which the particular offenders live. The appropriate minister should be advised whenever a lad from his district and of his faith is to appear in court. Magistrates possess the power to appoint ministers as probation officers on special cases and this is already being done.

Women officers should be somewhat different in type from the teachers. They should be well educated and possess some leisure with the desire to use it for the benefit of others. Other volunteer workers might be selected from men exempt from military service, and again from among convalescent soldiers. This last suggestion, though novel, deserves a fair trial as it should benefit both the men and the boys.

In all districts, councils of all workers for child welfare should be maintained. Parents should be taught to cooperate with magistrates and probation officers. They should realize their share of responsibility for their children's misdeeds.

If a fine is imposed the parents pay it and then probation supervision ends. It would often be better if the child under a longer period of probation could earn and pay his own fine. Flogging as a punishment ordered by the court is deprecated for several reasons. Punishment in itself is not a real remedy. Corporal punishment is demoralizing. Too long an interval necessarily exists between the offense and the punishment. It offers a simple solution, however, to the magistrate for many situations otherwise requiring thought.

Then there remains the commitment of delinquents to reformatories and industrial schools. For the last two years nearly all of these schools have been full. It is difficult to do justice to the subject of these schools. That the supervision of them is so good is a hopeful sign. That many of them are excellent training schools, there is no doubt. Yet in the average boy who comes from them we find much to be desired. Of the successes absorbed in the community, we know little. The sameness about the failures is disquieting. Again, the children coming now before the courts are largely of a type (and family history) that in normal times would not become offenders. Is it fair to them or good for them to incarcerate them among the types found in reformatories? "It is not a matter of reforming these children. It is not that they are misguided . . . they are unguided." It will be hard enough for the father on his return from war to find that his child has been an offender, but to find him confined in a reformatory would be intolerable. If the child be sent at all, it should be with an indeterminate sentence, depending on his conduct and the improvement in home conditions. He should be released as soon as possible. However, for the defective offender, an institution is probably the best place. Unfortunately many schools are unwilling to take them.

The councils or joint committees in work for children should restore as completely as possible opportunities for recreation such as playgrounds and children's clubs of all sorts. If a shortage of adult workers prevails, much help may be found among the lads themselves. They should be given as much responsibility as they can successfully carry. "Build the Juvenile Court with its back to a Common and its front to a Church; on one flank a gymnasium, and on the other a rifle-range—and a fine clubroom the Juvenile Court will make!"

A properly censored cinema is a most helpful recreation. "State censorship of films is already decided upon." It is interesting to learn that in Germany children under 17, even with adults, may not attend cinemas, unless these are certified by the police as harmless. In Russia teachers have the legal authority to permit or forbid attendance at the cinema. This entails their visiting the performances to learn whether they are good or bad. Sanitary conditions, lighting, ventilation and proper hours for performances for children should be established.

Having discussed methods for reorganization of the child's life on its social side, the author asks, "Is there any way in which the teaching that the children would, or should, normally have received from their parents, may be introduced into their lives, or is there anything we can substitute for it? . . . How can we reintroduce moral teaching to the children? . . . It is not enough that our education produces cleverness; it must produce also goodness. To train brains and ignore morals must spell disaster sooner or later." Herein, he thinks, lies the great opportunity for the church, the agency which should be most interested and most adequate. He deplores the fact that as a body it is still inadequate, but rejoices that many members of the ministry, having recognized the needs of children as being above all others, are with great self-sacrifice devoting themselves to this work.

As our entry into the war is later than England's, so is the accompaniment of these disturbances with us dependent upon the war. Happily, so far, there has not been an alarming increase of juvenile delinquency in this country. We can hardly hope that it will not come to a greater or less degree according to the means we employ to prevent it. If in this problem, as in others, England has learned from experience, we should then be glad to profit by what she tells us. If the following statement is true of England, it is equally true for us in this country and should increase our activities to prevent juvenile delinquency from becoming a plague among ourselves. "The blunt truth is that the state cannot afford juvenile offenders. With a population decimated by war, it is the concern of everyone to prevent waste of human material. Toward the spending of child life, especially of male child life, our attitude must be one of extreme parsimony."

ESTHER S. B. WOODWARD.

WHAT IS PSYCHOANALYSIS? By Isador H. Coriat, M.D. New York: Moffat, Yard and Company, 1917. 127 p.

The aim of this little volume, which can be read through in a few hours, is to answer the various inquiries which puzzle the lay public in a scientific field so new as that of psychoanalysis. Dr. Coriat has very ably performed this mission by putting the form of his text in questions and answers, and gives the reader a very clear understanding of the scope and meaning of psychoanalysis. At the end of this book, which students may read as a preliminary to taking up a psychoanalytic course of study, but which neurotic individuals would do better not to read if they intend to be psychoanalyzed, Dr. Coriat has collected a short bibliography, which will help one in a choice of reading upon the subject. The book as a whole can be thoroughly recommended.

L. PIERCE CLARK.

CHOOSING EMPLOYEES BY MENTAL AND PHYSICAL TESTS. By William Fretz Kemble. New York: The Engineering Magazine Company, 1917. 333 p.

At present we are witnessing the growth of a great popular interest in applied psychology. This popularity is calling forth an increasingly large amount of literature of a quasi-scientific character, and in this category the publication here considered belongs.

The book is written by a practical man, whose business it is to standardize the working forces of commercial concerns, and who has seen that psychology can be used in this business. His intention here is to present the theory and practice of choosing workers by means of tests, in lieu of choosing them by the old method of general impression. The intention is worthy, but it must be stated that at almost every turn Mr. Kemble does violence to the principles of modern psychology, both pure and applied.

Faculty psychology runs riot in the chapter on *The Five Forces of Personality*. The author says: "We now come to the five great forces arising from the store of memories and the physical make-up—*reasoning, imagination, egotism, ambition,* and *will*" (p. 228). The professional psychologist would dispute all the assumptions upon which such a sentence is based.

Throughout there is constant reference to "types." "A good reasoner is not necessarily a fast worker, his very type of mind leading him, possibly, to slow work" (p. 228); "Having found this type of mind, the problem is no longer that of the person, but of the job" (p. 151); "We will call them chaotic types" (p. 151); "The normal type of mind can make this appeal even better than an executive type" (p. 153). The fact that in the lexicon of scientific psychology there is, strictly speaking, no such word as "type" is unrecognized by Mr. Kemble.

The technique of mental and social measurement, upon which mental and social tests must invariably be founded, is very inadequately comprehended. The chapter on *The Three Laws of Labor Standardization* shows lack of familiarity with sound works on psychological method, such as Yule, Brown, or Thorndike. The author's amateurishness is nowhere more conspicuous than here. Such remarks as the following reveal the quality of the book as a whole: "We may conclude from these examples that observations based on averages computed on fewer than ten persons are not quite dependable when we are testing characteristics with possibilities of wide variance"!

Phrenology inspires many of Mr. Kemble's pages, in spite of his note that no sooner has one "nicely laid down a set of rules for the linings in the face" than "our intuitions tell us that the rules as set forth are untrue."

To record all the objections which the scientific psychologist would feel impelled to make to the statements which compose this volume, would carry us far beyond the limits of a book review. There is never reason to suspect the author's honesty of purpose. He combines the sincerity of the enthusiast with the naïveté of the amateur. The spirit of the book is progressive, but appreciation of sources of error, recognition of the tentative condition of vocational tests, and grasp of the scientific principles that underlie applied psychology are wholly inadequate. As a treatise on applications of psychology the volume lacks authority.

LETA S. HOLLINGWORTH.

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DIRECTORY OF SOCIETIES AND COMMITTEES FOR MENTAL HYGIENE

(Listed in the order of their origin)

The Connecticut Society for Mental Hygiene

(Organized, May, 1908)

39 Church Street, New Haven, Conn.
Miss V. M. Macdonald, Secretary
Miss Inez Newman, Associate Secretary

The National Committee for Mental Hygiene, Inc.

(Organized, February, 1909)

50 Union Square, New York City
Dr. Thomas W. Salmon, Medical Director
Dr. Frankwood E. Williams, Associate Medical Director
Clifford W. Beers, Secretary

The Illinois Society for Mental Hygiene

(Organized, July, 1909)

824 South Halsted Street, Chicago, Ill.
Miss Elnora E. Thomson, Executive Secretary
Mrs. Eleanor C. Slagle, Director of Occupations

Committee on Mental Hygiene of The New York State Charities Aid Association

(Organized, May, 1910; an outgrowth of an After-care Committee, organized in 1906)

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Miss Jessie Taft, Social Service Director

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(Organized, January, 1913)

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Dr. Charles E. Thompson, Secretary

The Mental Hygiene Society of Maryland

(Organized, March, 1913; an outgrowth of an After-care Committee, organized in 1911)

401 Garrett Building, Baltimore, Md.
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Kenneth L. M. Pray, Acting Secretary

The North Carolina Society for Mental Hygiene

(Organized, December, 1913)

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The Dayton Mental Hygiene Committee

(Organized, March, 1914)

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(Organized, April, 1915)

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Dr. W. D. Partlow, Secretary, Tuscaloosa, Ala.

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(Organized, March, 1916)

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88 Baldwin Block, Indianapolis

The Iowa Society for Mental Hygiene

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The Virginia Society for Mental Hygiene

(Organized, March, 1917)

Dr. William F. Drewry
Petersburg, Va.

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